

3369

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Middle River</u>		LENGTH OF STAY (in this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		<u>54</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>16 Dihedral Drive</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>TOMMIE C. ADCOCK</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>4-12 19 55</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>5-15-1907</u>	9. AGE last birthday: <u>47</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deck</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>MANUFACTURE</u>		11. BIRTHPLACE (State or foreign country): <u>ALABAMA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>TOMMIE ADCOCK</u>				14. MOTHER'S MAIDEN NAME: <u>HYATT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>918-05-2560</u>		17. INFORMANT & ADDRESS: <u>MARY ADCOCK</u> <u>SAME</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1
Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

1 1/2 hoursfour years

21. ACCIDENT (Specify) <u>no</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not while work at work		HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>April</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 14</u> , 19 <u>55</u> , and that death occurred at <u>10 A</u> m., from the causes and on the date stated above.									
SIGNATURE <u>Wm. A. Deak</u>		(DEGREE OR TITLE) <u>M.D.</u>		ADDRESS <u>901 Funelage on Balt. 20th</u>		DATE SIGNED <u>4-13-55</u>			
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4-15-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>		LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>4-13-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>John G. Connelley, Essex Md</u>		ADDRESS			

MARGIN RESERVED FOR BINDING



3370

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 CATONSVILLE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO., 28</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>327 HARLEM LANE</u>				STREET ADDRESS (If rural give location) <u>4215 BELLVUE AVE</u>			
3. NAME OF DECEASED: (First) <u>ANNIE</u> (Middle) <u>E.</u> (Last) <u>ALBERS</u>				4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>OCT. 4, 1872</u>	
9. AGE last birthday: <u>72</u> yrs.		10. AGE last birthday: If UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>CHARLES F. ALBERS</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE DUNKEL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>HELEN L. ALBERS</u> <u>ABOVE</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>420.1 Immediate cause (a) <u>Coronary Thrombosis</u></p> <p>Antecedent causes (b) <u>Coronary Sclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Arterio-sclerotic C-V Dis. Generalized arteriosclerosis</u></p>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized arteriosclerosis senile senescence</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1954</u> to <u>April 1955</u> , that I last saw the deceased alive on <u>March 9 1955</u> , and that death occurred at <u>April 11 5 am</u> , from the causes and on the date stated above.							
SIGNATURE <u>Kenneth Krulicich MD</u>				ADDRESS <u>400 W. Hilton St.</u> DATE SIGNED <u>4/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-13-1955</u>		<u>LODON PARK</u>		<u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>4-11-55</u>		<u>Dr. Hedrick</u>		<u>H.W. JENKINS & SONS Co.</u>		<u>4905 YORK RD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. K. KROELVITZ

400 N. HURON

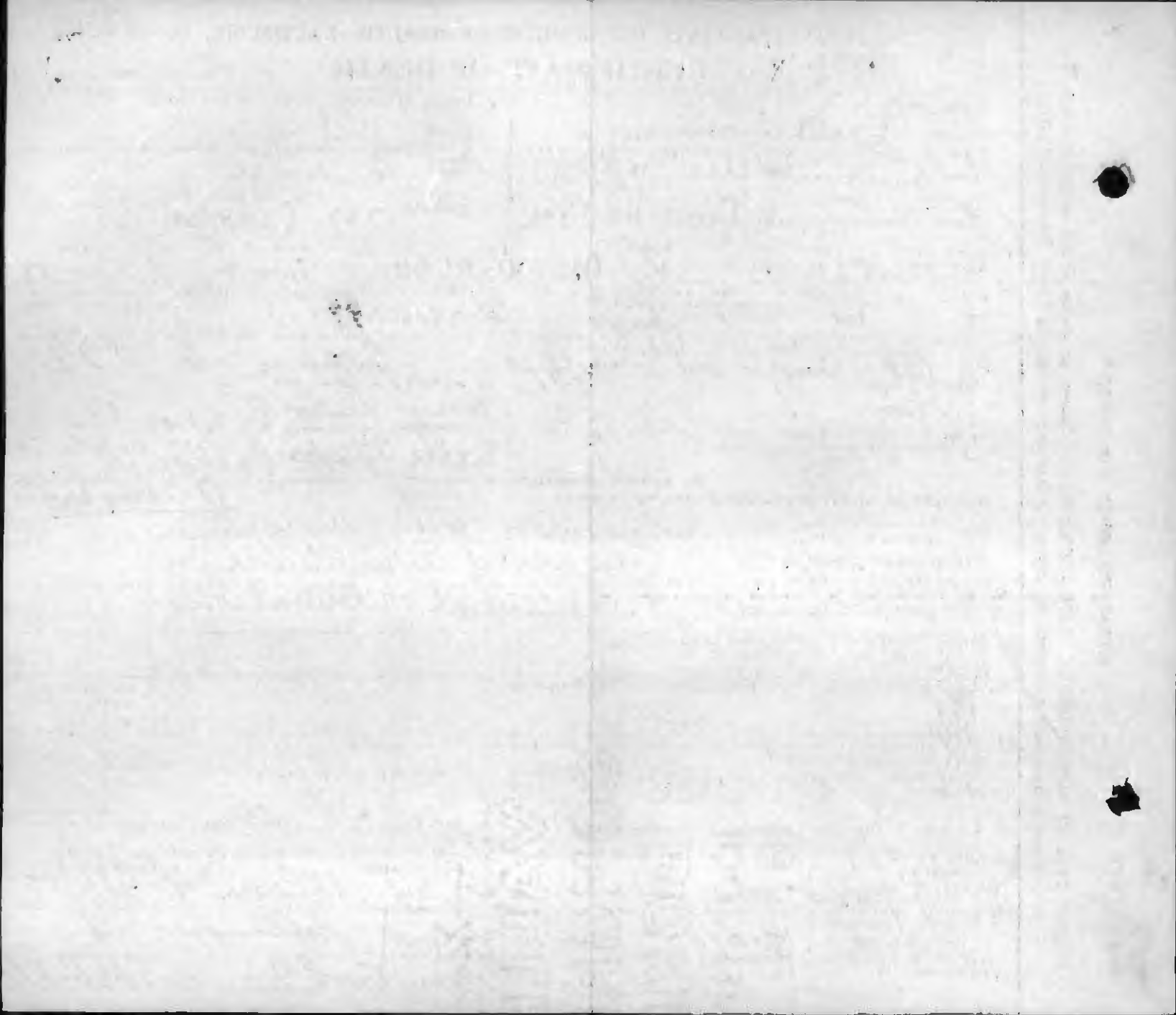
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3371 CERTIFICATE OF DEATH

03341

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR nearest town) <u>Catonsville</u>	LENGTH OF STAY (If this place) <u>4 1/2 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3601-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>		STREET ADDRESS (If rural give location) <u>739 Dolphin St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>CLARA V. ALLENBAUGH</u>		OF DEATH: <u>4</u> <u>9</u> <u>19 55</u>	
5. SEX: <u>+</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>About 1861</u>
9. AGE last birthday <u>94 (?)</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ret - Buyer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Dept. Store</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Leedon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT'S ADDRESS: <u>Relative (?)</u>		18. INTERVAL BETWEEN DEATH AND DEATH CERTIFICATE: <u>1909 W Fayette Baltimore, Md.</u>	
15. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334 X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Similarity with severe</u>			
DUE TO <u>Generalized atherosclerosis +</u>			
(B) <u>with cerebral deterioration</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/23</u> , 19 <u>54</u> to <u>4/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/9</u> , 19 <u>55</u> and that death occurred at <u>3:30</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Spring Grove Hospital Catonsville, Md.</u>		DATE SIGNED <u>4/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/12/55</u>	<u>New Cathedral</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-11-55</u>	<u>Dr. Hedrick</u>	<u>St. M. Cook & Co.</u>	<u>1217 B. Paul St.</u>



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03342

3372

CERTIFICATE OF DEATH

Reg. Dist. No. 28 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD		LENGTH OF STAY (in this place) 5 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 227 SUDBROOK LANE (PIKESVILLE)			
3. NAME OF DECEASED: (First) FRANCIS		(Middle) E.		(Last) ANDREWS		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 12 19 55	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED	8. DATE OF BIRTH: 1/15/88	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10B. KIND OF BUSINESS OR INDUSTRY: COURT		11. BIRTHPLACE (State or foreign country): TOWSON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JOHN ANDREWS				14. MOTHER'S MAIDEN NAME: MARY MORAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) WW I		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT & ADDRESS: CLIN.REC., VET.ADM.HOSP., FORT HOWARD, MD.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) THROMBOSIS OF MESENTERIC GLAND; HEMORR- GIC INFARCTION OF SMALL INTESTINE AND CECUM						8 DAYS	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APR. 7, 1955 , to APR. 12, 1955 , and that death occurred at 5:35 PM , from the causes and on the date stated above.							
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.				ADDRESS M.D. VAN, FORT HOWARD, MARYLAND DATE SIGNED 4-13-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 15, 1955		NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR APR 13, 1955		REGISTRAR'S SIGNATURE Harvey Newell		24. FUNERAL DIRECTOR ADDRESS HARVEY NEWELL FUNERAL HOME, REISTERSTOWN RD. PIKESVILLE, MARYLAND			

RECEIVED

APR 18 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03343
3373 CERTIFICATE OF DEATH Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>MT Carmel (Rural)</u> TOWN <u>3-0-4-10</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>MT Carmel (Rural)</u> TOWN <u>3-0-4-10</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>✓</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>EDDIE - C - ARMACOST</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 11 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>July 8 - 1884</u>	9. AGE last birthday <u>70</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Ind</u>	
13. FATHER'S NAME: <u>Joseph M Armacost</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Schultz</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-26-1484</u>		17. INFORMANT & ADDRESS: <u>Eletus Armacost, Upper Md</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MULTIPLE MYELOMA</u>							
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1954</u> to <u>April 1955</u> , that I last saw the deceased alive on <u>April 10, 1955</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. M. France</u>				ADDRESS <u>M. D. Parkton Ind.</u>		DATE SIGNED <u>4/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr 13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Baptist</u>		LOCATION (City, town, or county) (State) <u>Balto Co Ind</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-12-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Edw E. Tipton, Hampstead Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 18 1955
BUREAU V. S.

03344

MARYLAND

STATE DEPARTMENT OF HEALTH

3374

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7712 Old Hartford</u>		STREET ADDRESS (If rural, give location) <u>7712 Old Hartford Rd</u>	
3. NAME OF DECEASED (First) <u>HELEN</u> (Middle) <u>MARSHALL</u> (Last) <u>ASHLEY</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>10-26-1916</u>
9. AGE last birthday <u>38</u> yrs.		10. If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>et home</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Parkston N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13. FATHER'S NAME <u>George B Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Martha M. Carpenter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of <u> </u>)		16. SOCIAL SECURITY No. <u> </u>	
17. INFORMANT AND ADDRESS <u>Howard W. Ashley 7712 Old Hartford</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>14 yrs.</u>
(a) Immediate cause <u>345x Multiple Sclerosis</u>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u> </u>			

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>	
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13a. DATE OF OPERATION <u>none</u>	13b. MAJOR FINDINGS OF OPERATION <u> </u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11:07 a.m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>

22. I hereby certify that I attended the deceased from April, 1954, to 16 April, 1955, that I last saw the deceased alive on 15 March, 1955, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>Edward L. Hufnagel</u> (Degree or title)		ADDRESS <u>7425 Hartford Rd Balto Md</u>		DATE SIGNED <u>16 April 55</u> (State)
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>4-21-55</u>	NAME OF CEMETERY OR CREMATORY <u>Marland Park</u>	LOCATION (City, town, or county) <u>Balto Md</u>	
DATE REC'D BY LOCAL REG. <u>April 19/1955</u>	REGISTRAR'S SIGNATURE <u>H. H. Hedrich</u>	24. FUNERAL DIRECTOR <u>Benard H. H. H. H.</u>		ADDRESS <u>5305 Hartford</u>

MARGIN RESERVED FOR FINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3375 CERTIFICATE OF DEATH

03345

Reg. Dist. No.

WC

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u> LENGTH OF STAY (in this place) <u>1 Day</u>	STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 34. 1-4		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>712 N. Mount Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WAYMAN</u> (M) <u>AUGUSTUS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 30, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/23/96</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Shoe Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Shoe Co.</u>	
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Abraham Augustus</u>		14. MOTHER'S MAIDEN NAME: <u>Susie Frances</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>-I</u>		16. SOCIAL SECURITY NO. <u>214-01-1134</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>		<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROSIS OF THE LEFT MIDDLE CEREBRAL ARTERY</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
19A. DATE OF OPERATION: <u>5-4-1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>OLD RIGHT MIDDLE CEREBRAL ARTERY THROMBOSIS</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>VA</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 27, 1955</u> , to <u>Apr. 30, 1955</u> , and that death occurred at <u>8:55</u> M. from the causes and on the date stated above.			
SIGNATURE <u>W. C. DUDLEY</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
REGISTRAR'S SIGNATURE <u>W. C. Dudley</u>		24. FUNERAL DIRECTOR ADDRESS <u>Arlington S. Phillips Funeral Home</u>	
		<u>1808 N. Monroe Street, Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03346

3376

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Long Green</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Long Green</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Ludia</u> (Middle) <u>Ann</u> (Last) <u>Baker</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 18, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Harford County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Jackson Flowers</u>		14. MOTHER'S MAIDEN NAME <u>Ludia Fasten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>✓</u>	
17. INFORMANT AND ADDRESS <u>Winfield Baker, Glenn Arm # R.D.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.0 Coronary Infarction (3rd)</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arteriosclerotic Heart Disease</u>		
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

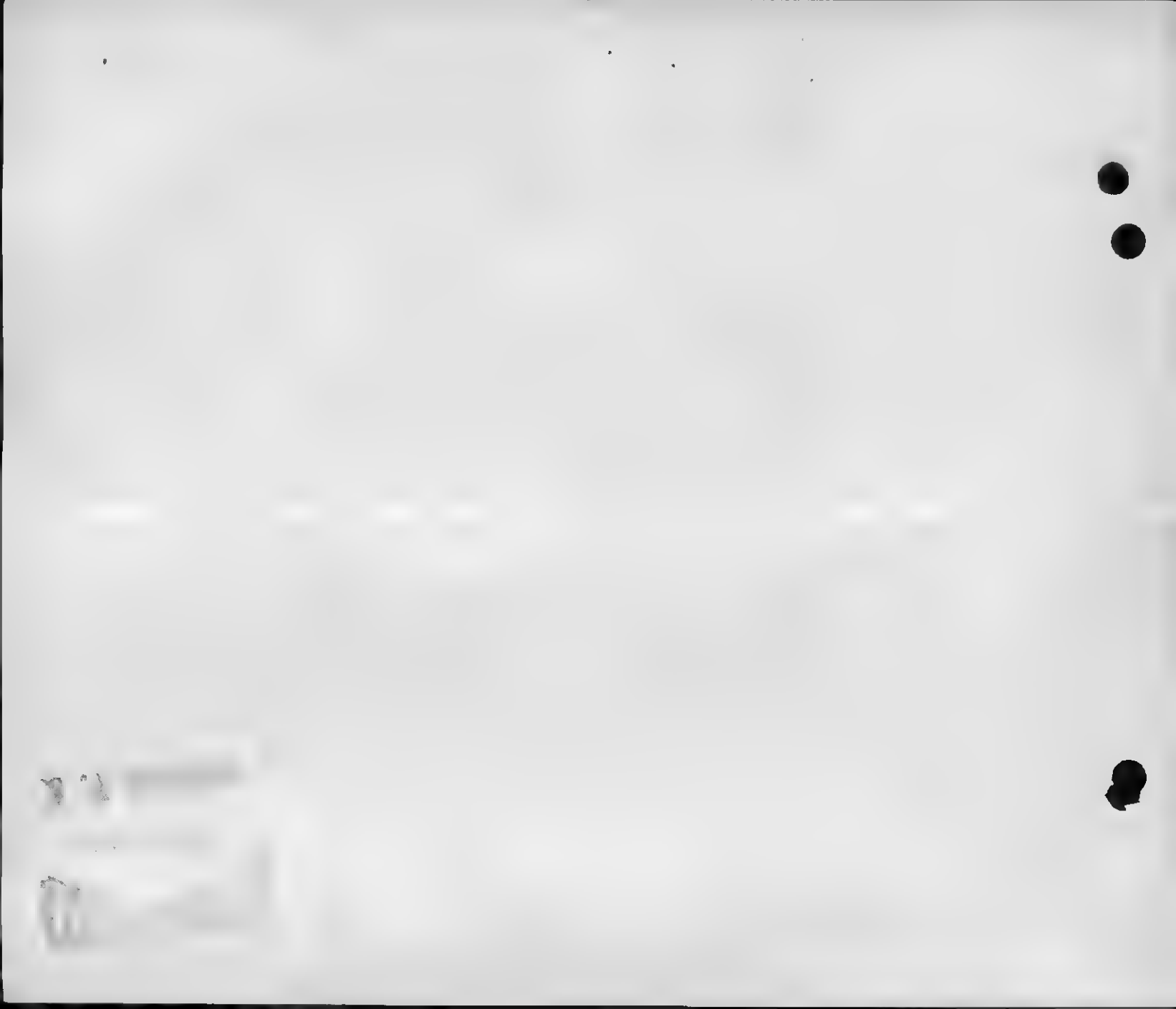
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9/21, 1953, to April 4, 1955, that I last saw the deceased alive on 4/3, 1955, and that death occurred at 11:45 A.M. from the causes and on the date stated above.

SIGNATURE <u>Jefford F. Hudson M.D.</u>		ADDRESS <u>Fork, Md.</u>		DATE SIGNED <u>4/4/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Fountain Green, Harford, Md.</u>		24. FUNERAL DIRECTOR <u>Joseph T. Foster, Bel Air, Md.</u>		ADDRESS	
DATE REC'D BY LOCAL REG. <u>4/11/55</u>		REGISTRAR'S SIGNATURE <u>Dr. Wm. Hammett</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

3377

2411 N. Charles Street, Baltimore

03347

CERTIFICATE OF DEATH

Reg. Dist. No. 33

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Hampstead Rural</u> LENGTH OF STAY (in this place) <u>Life</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hampstead Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Albany Lane</u>				STREET ADDRESS (If rural, give location) <u>Albany Lane</u>			
3. NAME OF DECEASED (Type or Print) <u>HARRY</u> (First) <u>WILSON</u> (Middle) <u>BOBBLITZ</u> (Last)		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1955</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 24, 1892</u>		9. AGE last birthday <u>62</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work doing most of working life, even if retired) <u>Streetcar Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Driving</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>August Bobblitz</u>				14. MOTHER'S MAIDEN NAME <u>Florence E. Albaw</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u> </u>		17. INFORMANT AND ADDRESS <u>Mrs. Florence E. Bobblitz, Hampstead Rd.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>443X Central Hemiparesis</u>						<u>8 hours</u>	
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u>						<u>(?)</u>	
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u> </u>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u> </u>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				(STATE)			
21. ACCIDENT (Specify) <u> </u>		PLACE (Home, farm, factory, street, or office bldg., etc.) <u> </u>		(CITY OR TOWN)		(COUNTY)	
SUICIDAL HOMICIDE		INJURY		HOW DID INJURY OCCUR?			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July 1, 1949</u> , to <u>April 16, 1955</u> , that I last saw the deceased alive on <u>April 16, 1955</u> , and that death occurred at <u>6:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush M.D.</u>				ADDRESS <u>Hampstead Rd.</u>		DATE SIGNED <u>April 16, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Grave Creek</u>		LOCATION (City, town, or county) (State) <u>Balto Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4-19-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		24. FUNERAL DIRECTOR <u>Edward C. Sipton</u>		ADDRESS <u>Hampstead Rd.</u>	

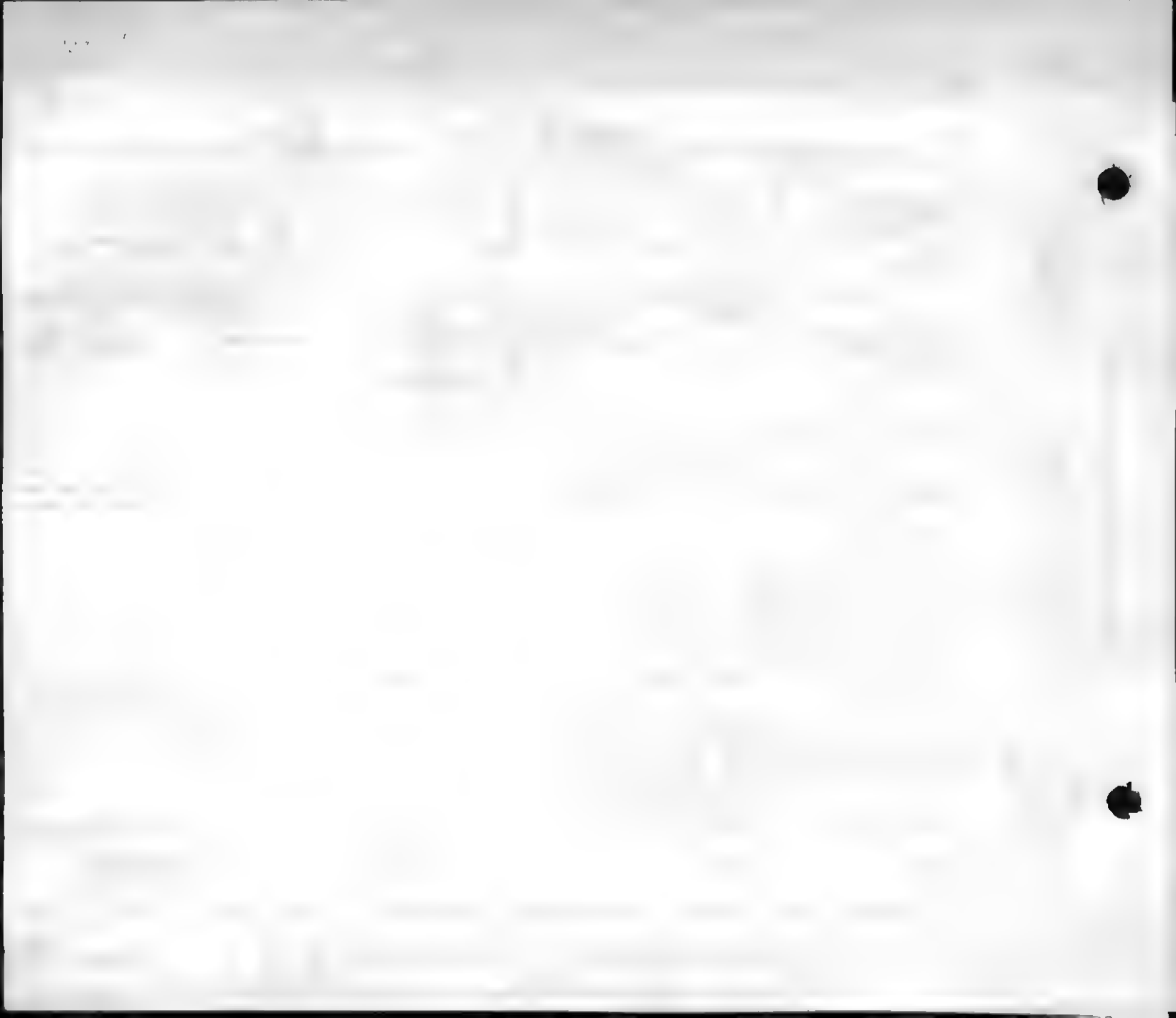
CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print)		CARRIE MARIE M. BENNER		2. DATE OF DEATH April 12, 1955	
3. PLACE OF DEATH: A. Baltimore City, Maryland		Woodlawn, Baltimore Co.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md.	
B. FULL NAME OF HOSPITAL OR INSTITUTION 2607 Larchmont Drive		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodlawn		D. STREET ADDRESS (If rural, give location) 2607 Larchmont Drive	
c. Length of stay in Baltimore 00 Yrs. Mos. Days		5. SEX female		6. COLOR OR RACE white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Aug. 6, 1893		9. AGE (in year last birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME George F. Mahle		14. MOTHER'S MAIDEN NAME Minnie Clifford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Paul A. Benner-2607 Larchmont Drive	
18. CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 416x ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					15 yr.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21C WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 12, 1955 to April 12, 1955, that (I) (we) last saw the deceased alive on April 12, 1955, and that death occurred at 12:30 A. M., from the causes and on the date stated above.					
23A. SIGNATURE D. J. Schwartz		23B. ADDRESS 2320 Eastwood Place		23C. DATE SIGNED April 12, 1955	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/15/55		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	
24D. LOCATION (City, town, or county) (State) Woodlawn, Md.		25. FUNERAL DIRECTOR J. M. J. Vickers & Sons		ADDRESS	

PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be fully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

MEDIC CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03349
3378
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
<u>Fort Howard</u>	<u>16 days</u>	TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>Veterans Administration Hospital</u>	<u>206 E. Melrose Avenue</u>		
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
First (Last)	(Middle)	OF DEATH	
<u>JOHN</u>	<u>C.</u>	<u>April 17 19 55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9/2/94</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):
<u>Watchman</u>		<u>Gas & Electric Co.</u>	<u>Baltimore Maryland</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Frank Benzinger</u>		<u>Mattie Carson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW-I</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>420.1</u>			
IMMEDIATE CAUSE		(A) <u>CORONARY THROMBOSIS</u>	
ANTECEDENT CAUSE (S)		DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B)	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?			
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
<u>VA</u>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 1, 1955</u> , to <u>Apr. 17, 1955</u> , the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>Francis G. Dickey, Chief, Medical Services</u>		<u>M. D. VAH, Fort Howard, Maryland</u>	
DATE SIGNED		DATE SIGNED	
<u>4-18-55</u>		<u>4-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Balto. National Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
<u>APRIL 21, 1955</u>		<u>Baltimore, Maryland</u>	
REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR	
		<u>Wm. Cook-Bright Inc., Funeral Home</u>	
		<u>Baltimore 14, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

3380

03350

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Providence</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 14 Providence Road</u>		STREET ADDRESS (If rural, give location) <u>Box 14 Providence Road.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Elbridge F. Biggs</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 25, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>12-24-1881</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year Months Days Hours Min. <u>19</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Test</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C. & P. Tel. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Milton E. Biggs</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Copeland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>212-05-0807</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Alice B. Mallonee Providence Rd.</u>		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>420.0 Coronary Arteriosclerosis</u>		<u>3-6 hours</u>
(b) <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arteriosclerotic Heart Disease</u>		<u>?</u>
(c) <u>Other significant conditions</u> Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec., 1954, to April, 1955, that I last saw the deceased alive on April 5, 1955, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE John J. Greenberg M.D. ADDRESS Medical Arts Bldg. DATE SIGNED 4/26/55

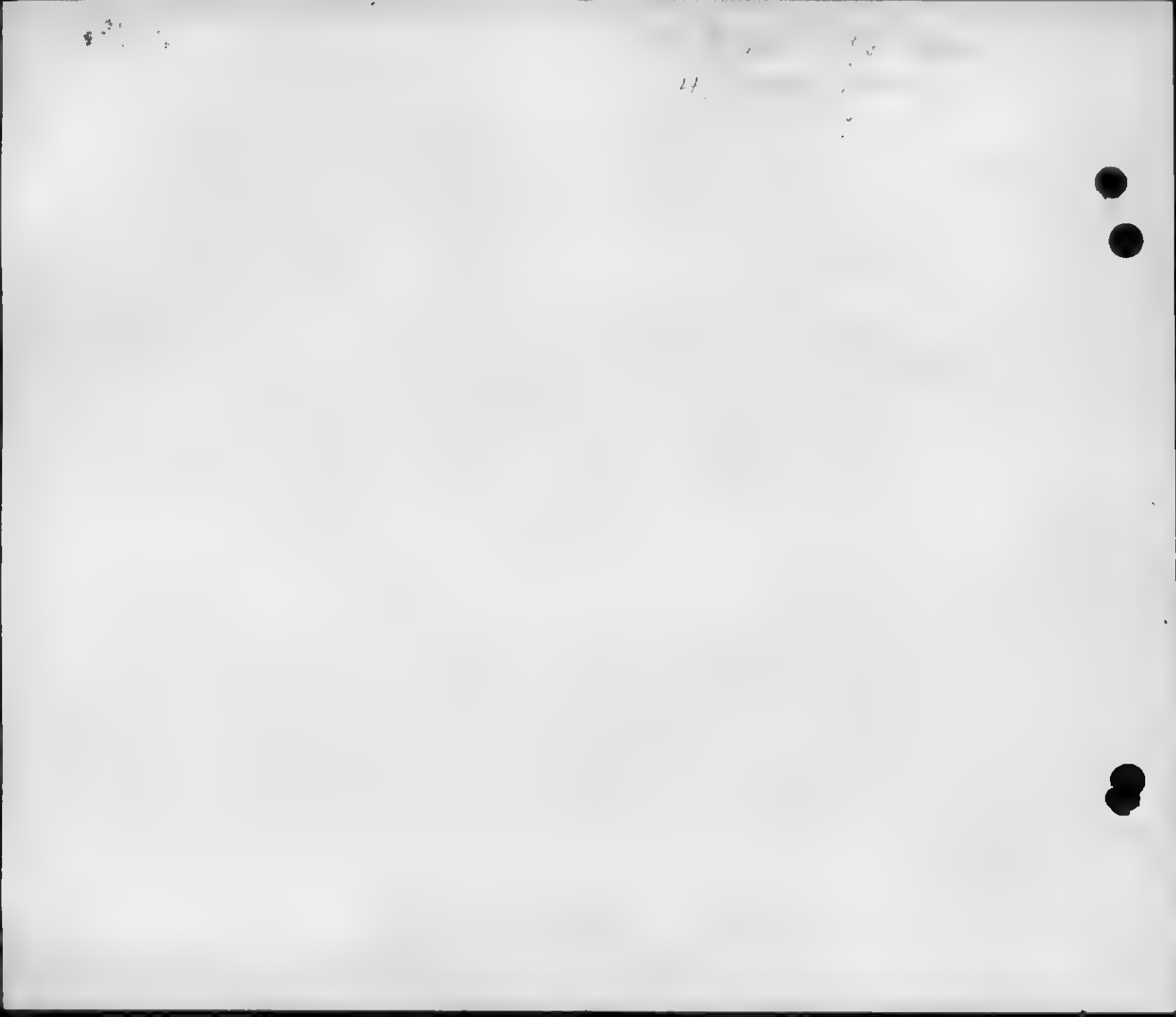
23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
4-26-1955 Frederick Mar. Cloister Frederick, Md.

DATE REC'D BY LOCAL REG. 4-26-55 REGISTRAR'S SIGNATURE W. H. Hatcher 24. FUNERAL DIRECTOR ADDRESS
A.R. Etchison & Son Frederick, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINNING

VS. A15



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803351

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTO. MARYLAND				STATE Md. COUNTY HARTFORD			
CITY (If outside corporate limits, write RURAL) CATONSVILLE LENGTH OF STAY (in this place) 23 months				CITY (If outside corporate limits, write RURAL and give nearest town) Aberdeen 12312			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hospital				STREET ADDRESS (If rural give location) Aberdeen ✓			
3. NAME OF DECEASED (Type or Print) CLYDE A. BLEVIN S				4. DATE (Month) (Day) (Year) OF DEATH: 4-23-1955			
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S	8. DATE OF BIRTH: 1901	9. AGE last birthday 54 yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): MARYLAND	
13. FATHER'S NAME: TROY BLEVENS				14. MOTHER'S MAIDEN NAME: CYNTHIA C. CANDILL			
15. WAS DECEASED EVER IN U.S. ARMY OR FOREST (Yes, no, or unk.): No If Yes, give war or dates of service:				16. SOCIAL SECURITY NO. NONE			
17. INFORMANT & ADDRESS: Bertha Day 320 S. Phila. BLVD. Aberdeen, Md.				18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
IMMEDIATE CAUSE 490X				DUE TO (A) Left lobar pneumonia			
ANTECEDENT CAUSE (S)				DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				DUE TO (C)			
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-19-1953 to 4-23-1955 , that I last saw the deceased alive on 4-23-1955 and that death occurred at 2:45 PM , from the causes and on the date stated above.							
SIGNATURE Harold E. Edwards M.D.				DATE SIGNED 4-24-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF April 26, 1955			
NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				LOCATION (City, town, or county) (State) Bel Air, Md.			
DATE REC'D BY LOCAL REGISTRAR 4/27/55				REGISTRAR'S SIGNATURE Victor S. Harry			
24. FUNERAL DIRECTOR Joseph Turner Foster				ADDRESS West Broadway, Bel Air, Md.			



3352

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>BALTO.</u>	MARYLAND		STATE <u>MD</u>	COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN <u>DUNDALK 02</u>	<u>5 1/2</u>		TOWN <u>DUNDALK 22</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7308 FAIT AVE</u>			STREET ADDRESS (If rural give location) <u>7308 FAIT AVE</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>WILLIAM E BOWERS, SR.</u>			<u>4-6-1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS.
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>3-7-1904</u>		<u>51</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>FOREMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>SHIP BUILDING</u>		11. BIRTHPLACE (State or foreign country): <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			13. FATHER'S NAME: <u>GEORGE BOWERS</u>		
14. MOTHER'S MAIDEN NAME: <u>ELIZABETH WINEBURG</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY No.: <u>216-10-4813</u>			17. INFORMANT & ADDRESS: <u>AMELIA H. BOWERS</u> <u>ADDRESS</u>		

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <u>CORONARY OCCLUSION</u>				<u>24 Hours</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>HYPERTENSION - Arterio-Sclerosis</u>				<u>1 year?</u>	
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>✓</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>54</u> , to <u>Apr 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr. 6</u> , 19 <u>55</u> , and that death occurred at <u>5 a.m.</u> , from the causes and on the date stated above.					
SIGNATURE <u>Morris A. Jacob</u>		(Degree or title) <u>MD</u>		ADDRESS <u>1610 NORTH POINT RD. BALTO. MD.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>4-6-55</u>		<u>WOODSON PARK</u>	
LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>BALTO. MD.</u>		<u>April 6-1955</u>		<u>William M. Kelly</u>	
REGISTRAR'S SIGNATURE		ADDRESS			
<u>William M. Kelly</u>		<u>1610 North Point Rd., Dundalk, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BOUND J. V. S.

1887

1887

MARYLAND STATE DEPARTMENT OF HEALTH

03353

3382

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>70</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u>	(Middle) <u>HENRY</u>	(Last) <u>BRADY</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>1-26-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Newspaperman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>DARTSVILLE W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>PETER GRADY</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE MILLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>WM GRADY, WOODLAWN MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>151X</u>		<u>Carcinoma of stomach</u>	<u>3 months</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardio Vascular Disease</u>			<u>13 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <u>no operation</u>		19b. MAJOR FINDINGS OF OPERATION <u></u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR? <u></u>	

22. I hereby certify that I attended the deceased from Dec 11, 1942, to April 20, 1955, that I last saw the deceased alive on April 15, 1955, and that death occurred at 6 A. m., from the causes and on the date stated above.

SIGNATURE Joshua H. Amos M.D. ADDRESS 6419 Winder Hill Rd Baltimore - 7 Md DATE SIGNED 4-20-55

23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE <u>4-22-55</u>	NAME OF CEMETERY OR CREMATORY <u>NEW BETHEL</u>	LOCATION (City, town, or county) (State) <u>MARTINSBURG W. VA</u>
DATE REC'D BY LOCAL REG. <u>4-20-55</u>	REGISTRAR'S SIGNATURE <u>Aug. C. Russell</u>	24. FUNERAL DIRECTOR <u>F. HIGGINBOTHAM - ELICOTT CITY Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 22

1951

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03354

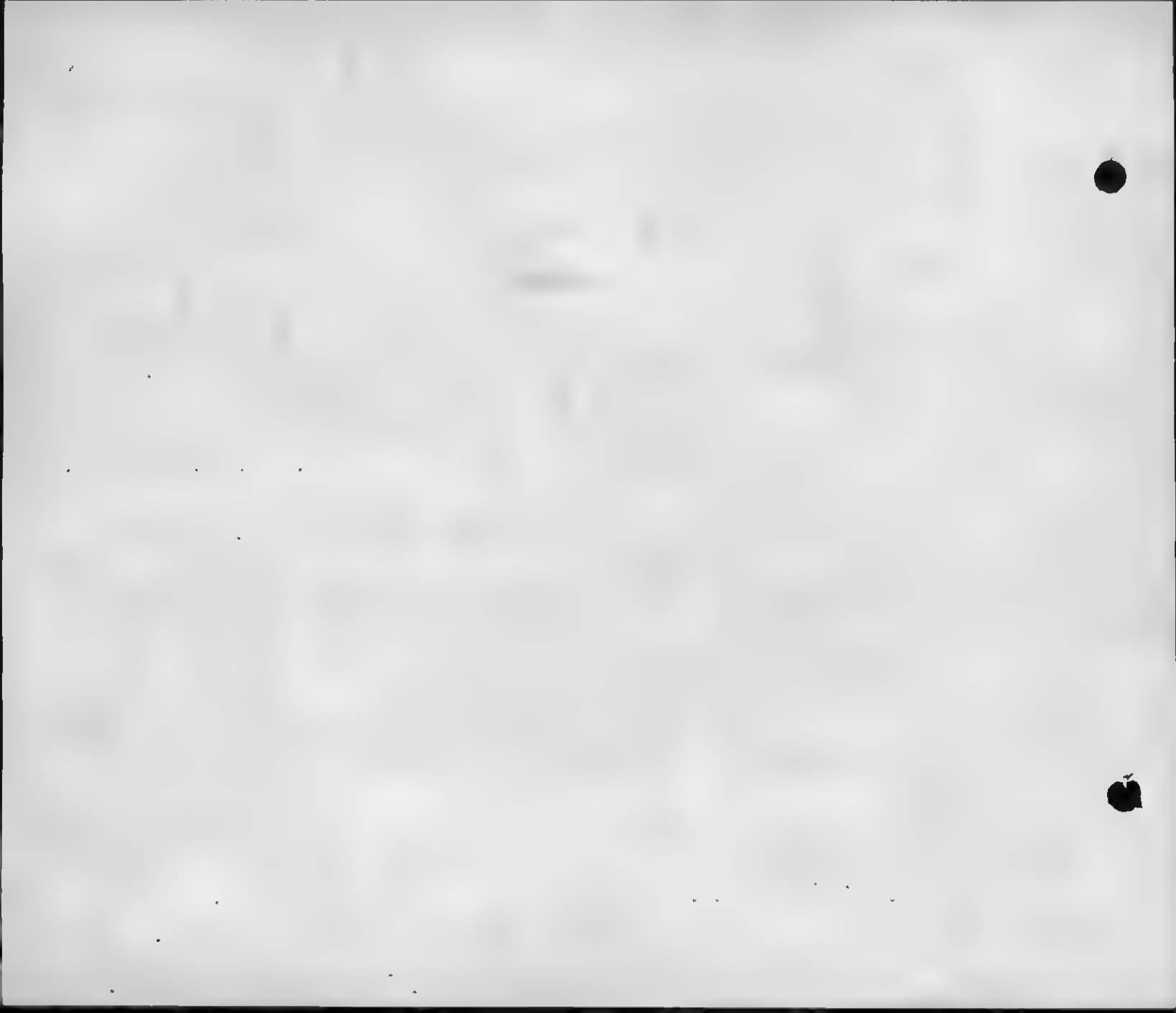
Item 9, Film 100 4-1-55 ct

CERTIFICATE OF DEATH

Reg. Dist. No.

3383

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY _____
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
<u>FORT HOWARD</u>	<u>9 DAYS</u>	<u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>VETERANS ADMINISTRATION HOSPITAL</u>		<u>555 PRESSMAN STREET</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
<u>BRITTO, I. JOHN</u>	<u>APRIL 7 1955</u>		
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>7/27/15</u>
9. AGE last birthday <u>39</u> yrs. <u>36</u> months <u>3</u> days <u>3</u> hours <u>3</u> min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>JANITOR</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>ANTONIO BRITTO</u>		14. MOTHER'S MAIDEN NAME: <u>NANNIE MARIE BILLEPS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service, <u>WW II</u>) <u>YES</u>		16. SOCIAL SECURITY NO. <u>039-03-8315</u>	
17. MEDICAL CERTIFICATION		18. CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
465X THROMBOSIS OF SUPERIOR VENA CAVA AND		2 Weeks	
IMMEDIATE CAUSE (A) <u>TRIBUTARIES; PULMONARY EMBOLISM, RT. LUNG</u>			
ANTECEDENT CAUSE (B) <u>UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>MARCH 29 1955</u> , to <u>APRIL 7, 1955</u> , that he died on <u>APRIL 7, 1955</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE OF PHYSICIAN <u>William B. Vandegrift, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u> DATE SIGNED <u>4/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Joseph L. Russ Funeral Home</u>		ADDRESS <u>2222 W. North Ave. Baltimore, Md.</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, in the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03355

3384

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Baltimore
 City or town X Mt. Washington
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
6071 Falls Road.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Ma County Balto
 City or town Mt. Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6071 Falls Road.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.

3. (a) FULL NAME

Rose Ella Brookhart.

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Benjamin Brookhart
Deceased 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) June 15, 1870
 8. AGE: Years 84 Months Days If less than one day hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Nathaniel Gover

13. Birthplace Md

14. Maiden name Martha ?

15. Birthplace Md.

16. Informant Miss Anna E. Wilson.

Address 6071 Falls Road.

17. Burial Date thereof April 25/55
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pine Grove

Location Balto Co. Md

18. Funeral director Austin E. Donovan

Address 3818 Roland Ave

19. April 23, 1955
 (Date filed by registrar)

R.W. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April 22, 1955

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 18, 1955 to Apr 22, 1955

and that I last saw her alive on Apr 20, 1955

Immediate cause of death Coronary Heart Failure DURATION 4 days

Due to arteriosclerosis

Due to C.V. Dis. 422.1

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. E. Donovan M. D. or other

Address 6071 Falls Rd Date signed 4/23/55



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY BALTO MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL BALTO LENGTH OF STAY (in this place) ?
HOSPITAL OR INSTITUTION OR STREET ADDRESS WOODBROOK LANE

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL BALTO X
STREET ADDRESS (If rural give location) WOODBROOK LANE 1

3. NAME OF DECEASED:

(First) RIGGIN (Middle) BUCKLER (Last)

4. DATE OF DEATH: (Month) Apr (Day) 27 (Year) 1955

5. SEX:

M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH:

Nov 3 1882 72 yrs.

9. AGE last birthday: If UNDER 1 YEAR If UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Architect

10b. KIND OF BUSINESS OR INDUSTRY:

OWN FIRM

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Riggin Buckler

14. MOTHER'S MAIDEN NAME:

Alice W Riggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No.

-

17. INFORMANT & ADDRESS:

Mrs Riggin Buckler SAME

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a)

arteriosclerotic heart disease

Interval Between Onset and Death

9 yrs.

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

arteriosclerosis - generalized
15 yrs.

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1, 1955, to June 27, 1955, that I last saw the deceased

alive on June 22 1955, and that death occurred at 12:50 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

C. Duemus Bonds M.D.
24 E. Eager St
7/28/55

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(STATE)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FURNERAL DIRECTOR

ADDRESS

7-28-55
Dr. Duemus
Wm. E. Eager
4905 York Rd

MARGIN RESERVE FOR INDEXING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct are is especially important. Physicians: please write the causes of death clearly and legibly.

[illegible]

3386

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Parkton Rural</u>		<u>36 yrs</u>		OR TOWN <u>Parkton Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Erma</u>				STREET ADDRESS (If rural, give location) <u>Erma</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Lula Bell Bull</u>				<u>April 27 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>June 15, 1889</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Thompson</u>				<u>Georgie Pearce</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
<u>No</u>						<u>Mrs. Elmer Layesman, Parkton Rd</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>154X Immediate cause (a) <u>Generalized Carcinomatosis</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>Primary Carcinoma of Rectum.</u> DUE TO</p> <p>(c)</p>							
2. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY?	
<u>March 31 1949</u>				<u>Primary Carcinoma Rectum</u>		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office, etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>March 1, 1949</u> , to <u>April 27, 1955</u> , that I last saw the deceased alive on <u>April 27, 1955</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE				(DEGREE OR TITLE)		DATE SIGNED	
<u>Brook E. Bush</u>				<u>M.D.</u>		<u>4/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>April 30, 1955</u>		<u>Wt. Md.</u>		<u>Parkton, Md.</u>	
DATE REC'D BY LOCAL		RECEIVER'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Apr 27 1955</u>		<u>Charles J. Reardon</u>		<u>John H. Henderson</u>		<u>New Freedom</u>	

MARGIN RESERVED FOR BINDING

VS. A15 3-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 A 053100

10 0 1

10 0 1

3387

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO. CO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1300 Summit Ave</u>		STREET ADDRESS (If rural, give location) <u>1300 Summit Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>C. Caronic Stephen Cahill</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 9/55</u> 19 <u>55</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 11, 1888</u>
9. AGE last birthday <u>67</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Indiana</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Manager</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael Cahill</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ryan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>182-09-7762</u>	
17. INFORMANT <u>Mary C. Cahill</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Coronary Occlusion</u>		<u>20 min.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death. <u>Acute & chronic alcoholism</u>	<u>10 months</u>
--	------------------

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<u>None</u>	<u>None</u>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None</u>	PLACE (Home, farm, factory, street, office hldg., etc.) OF INJURY <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) D. D. Caples M.D. ADDRESS 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 4/11/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/12/55</u>	NAME OF CEMETERY OR CREMATORY <u>N. CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>CHILP. PA.</u>
DATE REC'D BY LOCAL REG. <u>4/11/55</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	24. FUNERAL DIRECTOR <u>MacLabb & Son</u>	ADDRESS <u>Catonville Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

105

CERTIFICATE OF DEATH

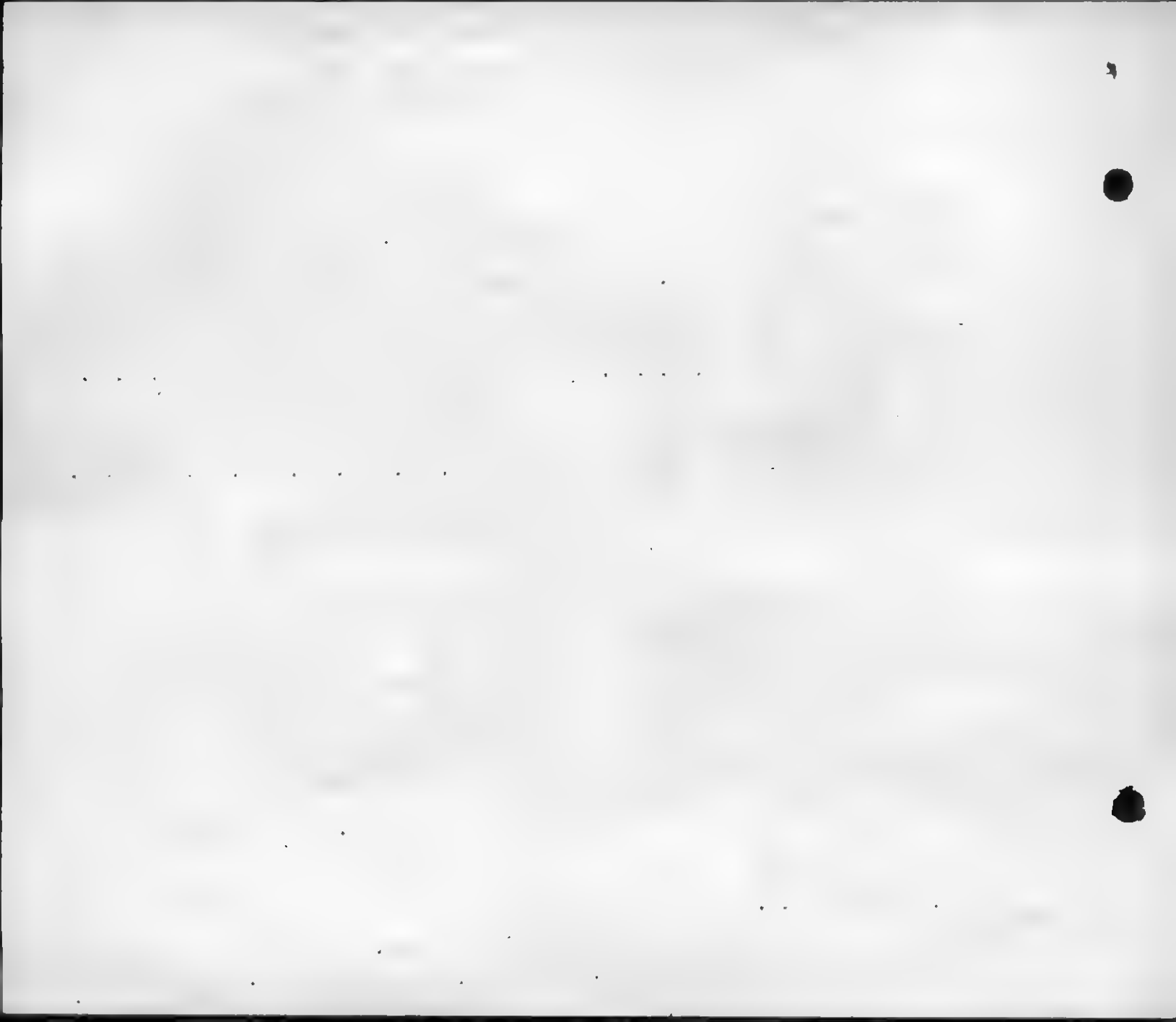
Reg. Dist. No. 44

3388

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 74 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 5915 BENTON HEIGHTS AVENUE	
3. NAME OF DECEASED: (Type or Print) DANIEL S. CALWELL		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 16 1955	
5. SEX MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: 2-12-98
9. AGE last birthday 57 yrs		10. MONTHS 5 DAYS 16 HOURS 15 MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ELECTRICIAN		10B. KIND OF BUSINESS OR INDUSTRY: B.&O.R. R.	
11. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: JAMES S. CALWELL		14. MOTHER'S MAIDEN NAME: AMANDA SCOTT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) YES (If Yes, give war or dates of service) WW-I		16. SOCIAL SECURITY NO 553-10-2191	
17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 163X			
ANTECEDENT CAUSE (S): (A) ANAPLASTIC TRANSITIONAL CELL CARCINOMA, (B) ENKX LEFT LUNG		UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB. 1, 1955 , to APR. 16, 1955 , and that death occurred at 4:50 A.M. from the causes and on the date stated above.			
SIGNATURE JOHN A. SURMONTE, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 4-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 19, 1955	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM.		LOCATION (City, town, or county) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-19-55		REGISTRAR'S SIGNATURE A. W. H. H. H.	
24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc. Funeral Home		ADDRESS 6009 Harford Road, Baltimore 14, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 4

3389

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>HAREWOOD PK</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>HAREWOOD PK</u>	<u>X</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ROUTE 14 BOX 408</u>		STREET ADDRESS (If rural give location) <u>ROUTE 14 BOX 408</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>George Washington Carback</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>April 20 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>AUG. 12-1874</u>
9. AGE last birthday: <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>JOHN CARBACK</u>		14. MOTHER'S MAIDEN NAME: <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>215-22-2600</u>	
17. INFORMANT & ADDRESS: <u>Edward Carback</u>		18. Same as above.	

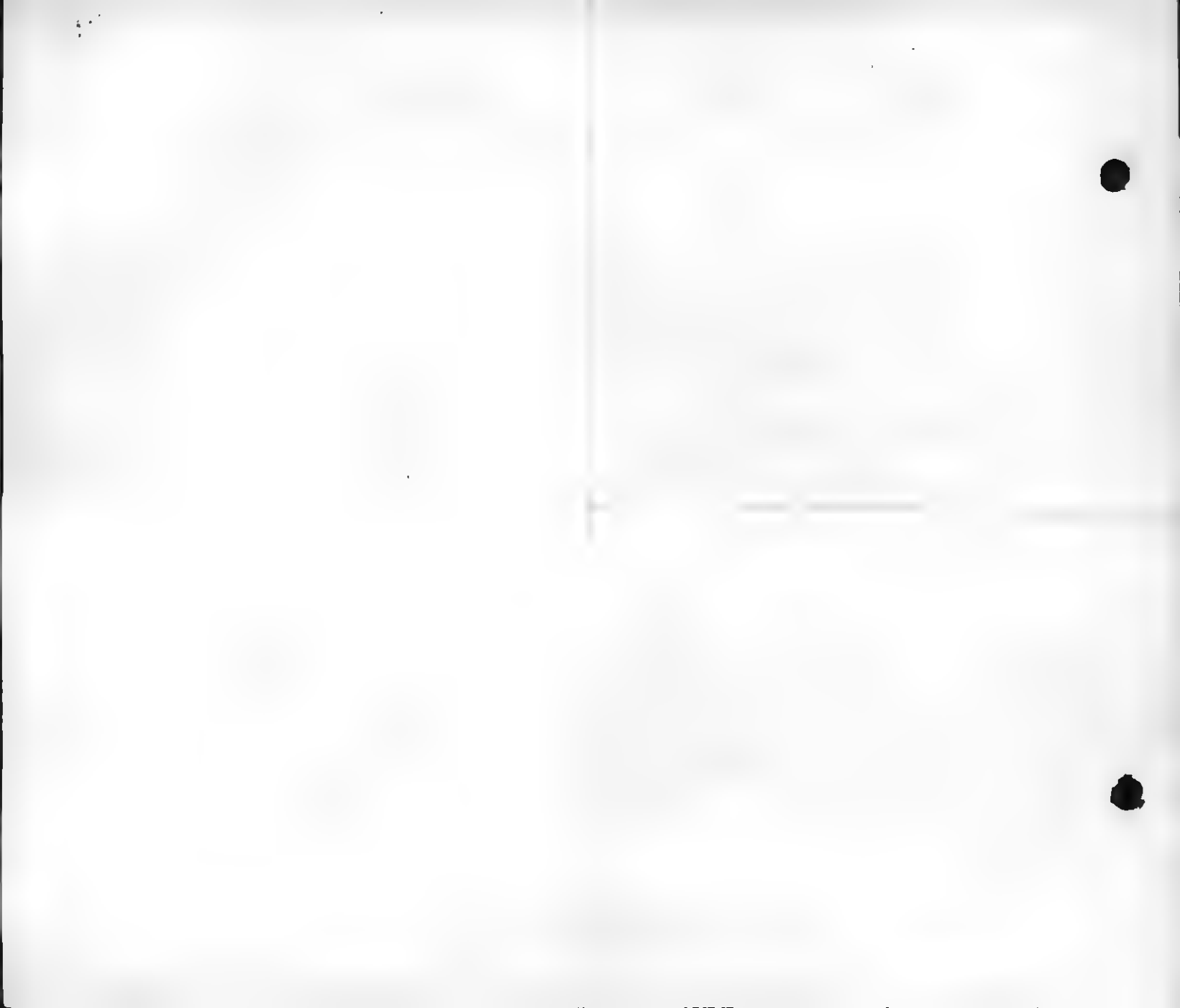
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
427. Immediate cause (a) <u>Cerebral apoplexy.</u>		<u>Sudden</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerosis Cardiovascular disease</u>		<u>2 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Stomach</u>		
19a. DATE OF OPERATION: <u>May 1954</u>	19b. MAJOR FINDINGS OF OPERATION: <u>Partial Gastrectomy</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>March 1, 1955</u> , to <u>April 20, 1955</u> , that I last saw the deceased alive on <u>April 20, 1955</u> , and that death occurred at <u>3:16 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. M. B. Quinn</u>	(Degree or title)	ADDRESS <u>Balto 6 Md</u>	DATE SIGNED <u>4/24/55</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>4/23/55</u>	<u>EBENEZER CEM</u>	<u>BALTO. CO. MD.</u>
DATE REC'D BY LOCAL REGISTRAR <u>4-22-55</u>	REGISTRAR'S SIGNATURE <u>Am. Federal</u>	24. FUNERAL DIRECTOR <u>John D. Connelly</u>	ADDRESS <u>East Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03361
3390 CERTIFICATE OF DEATH

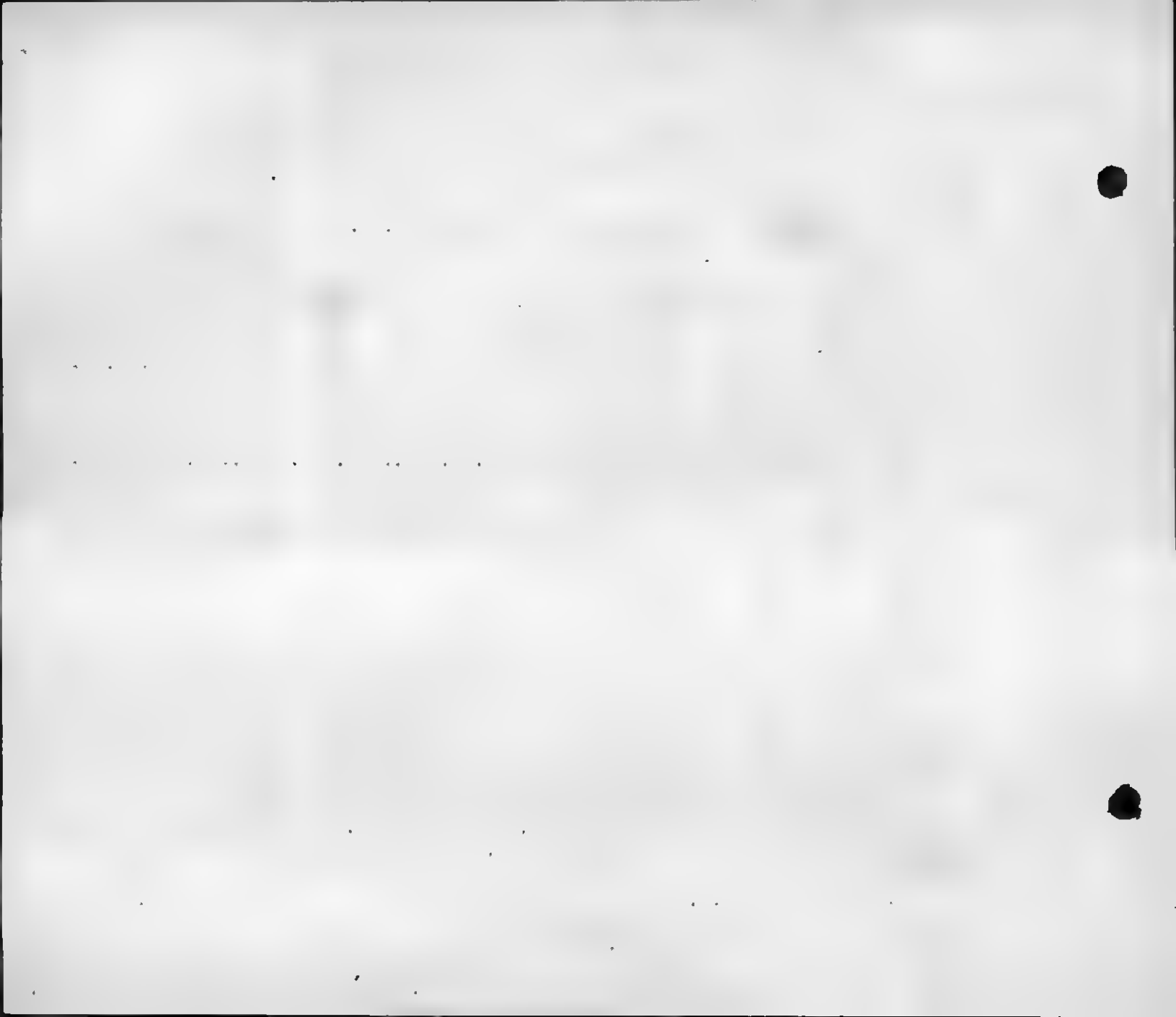
Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTIMORE	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)	FORT HOWARD	CITY (If outside corporate limits, write RURAL and give nearest town)	GLENARM
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS	P. O.
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	JAMES H. CASTERLOW	OF DEATH:	APRIL 20 19 55
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
MALE	COLORED	MARRIED	FEBRUARY 3, 1896 59 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (Stat. or foreign country)
Stone Crusher		Stone Quarry	LONG GREEN, MARYLAND
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
JAMES CASTERLOW		ROSIE ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
YES WW-I		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.		I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE		(A) HYPERTENSIVE CARDIOVASCULAR DISEASE	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSE (S)		DUE TO	2 YEARS
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B)	
		DUE TO	
		(C)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
VA M.		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APR. 8, 1955, to APR. 20, 1955, that I last saw the deceased on APR. 20, 1955, and that death occurred at 1:45 PM, from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
WILLIAM B. VANDEGRIFT, M.D.		M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED		DATE SIGNED	
4-22-55		4-21-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		MT. ZION CHURCH CEMETERY	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
4-22-55		LONG GREEN, MARYLAND	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
C. W. H. H. H.		Arlington S. Phillips Funeral Home	
		1808 N. Monroe Street, Baltimore 17, Md.	

MARGIN RESERVED FOR BINDING

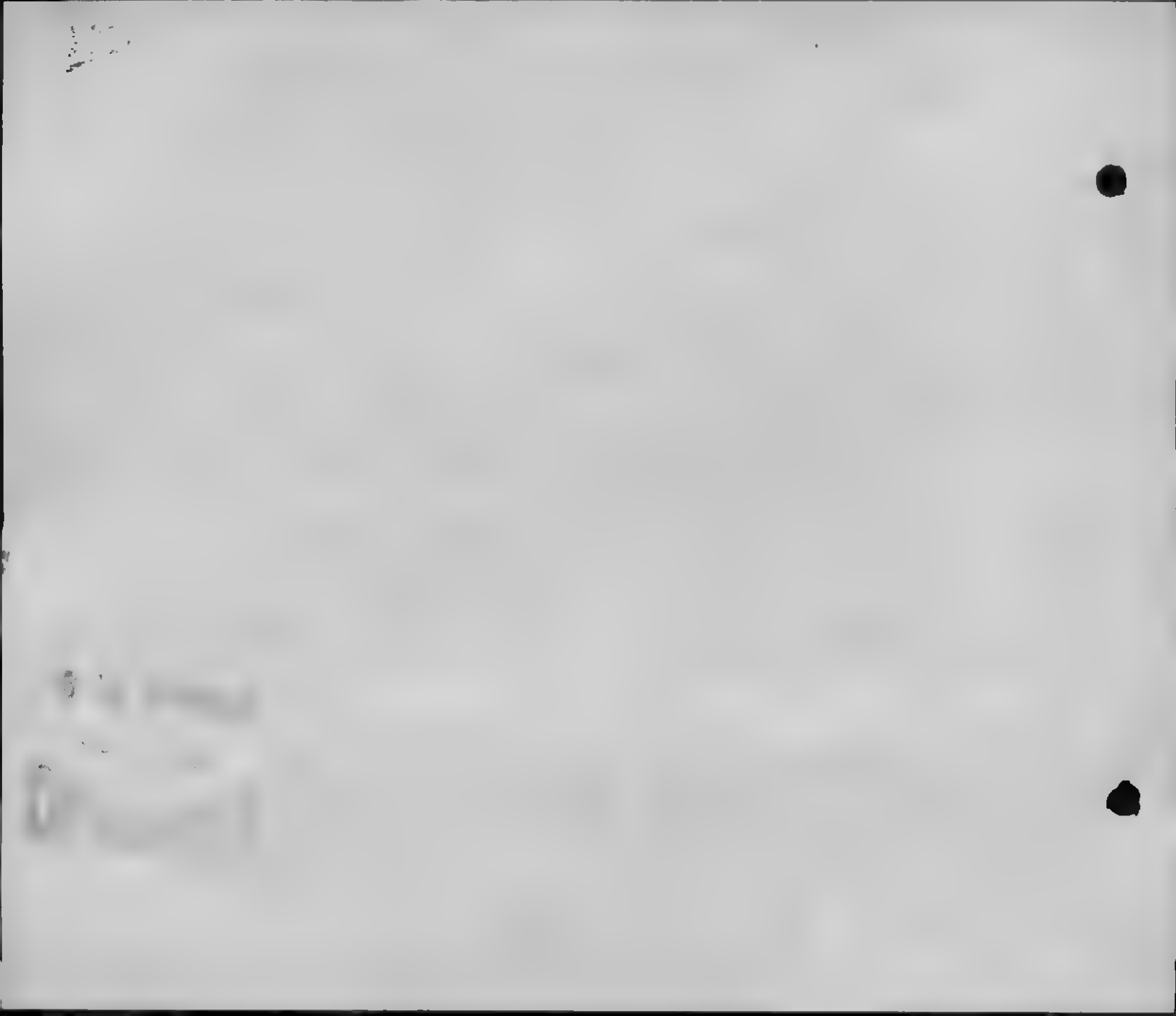
VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3391		03362	
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 37			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>COCKEYSVILLE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>TOWSON</u>	<u>55</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>N. Pott Spring Road</u>		STREET ADDRESS (If rural, give location) <u>12 W. JOPPA ROAD</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Benjamin</u>	(Middle) <u>Franklin</u>	(Last) <u>Cavey Jr</u>	(Month) <u>April</u> (Day) <u>5</u> (Year) <u>1955</u>
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>JUNE 7, 1915</u>
9. AGE last birthday: <u>39</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>PRINTER</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>BENJAMIN F. CAVEY, SR.</u>	
14. MOTHER'S MAIDEN NAME: <u>LULA PRUITT</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WW II</u>	
16. SOCIAL SECURITY No.: <u>215-07-5289</u>		17. INFORMANT & ADDRESS: <u>SERVICE RECORD</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carbon monoxide poisoning (in auto)</u>			<u>Sudden</u>
Antecedent cause(s) (b) <u>DUE TO</u>			
Diseases or conditions, if any, giving rise to the above cause <u>DUE TO</u>			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County)	(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Bollinb. Hudson D.M.E.</u>		CHIEF MEDICAL EXAMINER DATE SIGNED <u>4/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEM.</u>	
DATE THEREOF <u>APRIL 8, 1955</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
DATE REC'D BY LOCAL REG. <u>12 April 1955</u>		24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Md.</u>	

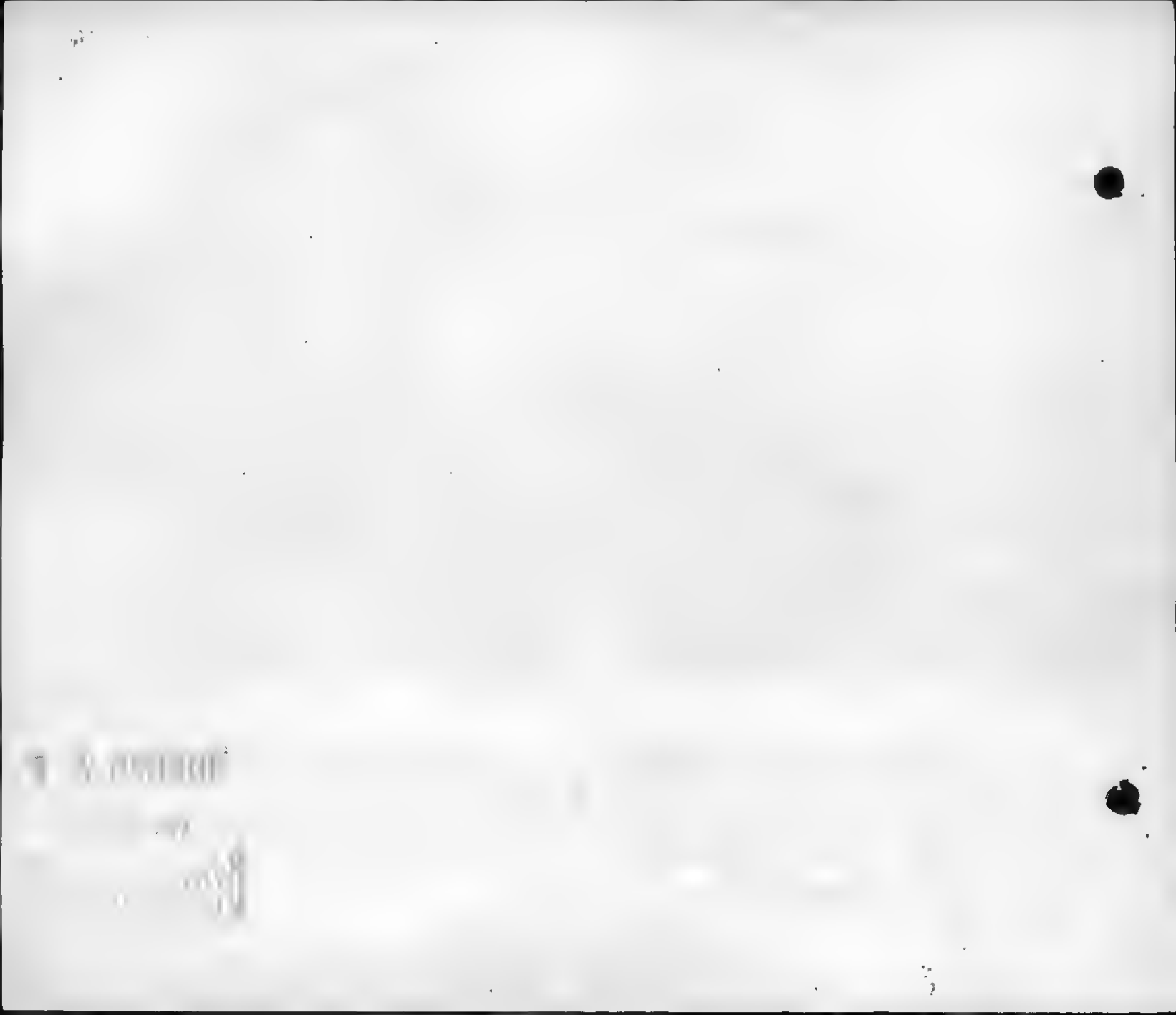


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03363
3392 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FORT HOWARD</u>		<u>40 Days</u>		TOWN <u>SNOW HILL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>R.F.D. #2</u>			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>WOODY</u>		<u>CHATHAM</u>		<u>APRIL</u>		<u>23</u> , <u>19</u> <u>55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH.	9. AGE last birthday		IF UNDER 1 YEAR: IF UNDER 24 HRS.	
<u>MALE</u>	<u>WHITE</u>	<u>SINGLE</u>	<u>5-2-91</u>	<u>63</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>Farm</u>		<u>Worcester Co., Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>ELIJAH CHATHAM</u>				14. MOTHER'S MAIDEN NAME: <u>ARLENE STEWART</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>WW-1</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>						<u>24 HOURS</u>	
ANTECEDENT CAUSE (B) DUE TO <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>						<u>10 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHIAL ASTHMA; PULMONARY EMPHYSEMA</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH, (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
M							
22. I hereby certify that I attended the deceased from <u>March 14, 1955</u> to <u>April 23, 1955</u> and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Joseph Shear</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>4-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4-26-55</u>		<u>OLIVET CEMETERY</u>		<u>WORCESTER CO., MARYLAND</u>	
DATE RECD BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>George L. Schrab</u>		24. FUNERAL DIRECTOR		ADDRESS	
<u>April 27-55</u>				<u>2101 Frederick Ave., Baltimore, Maryland</u>			



3392

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03364

CERTIFICATE OF DEATH

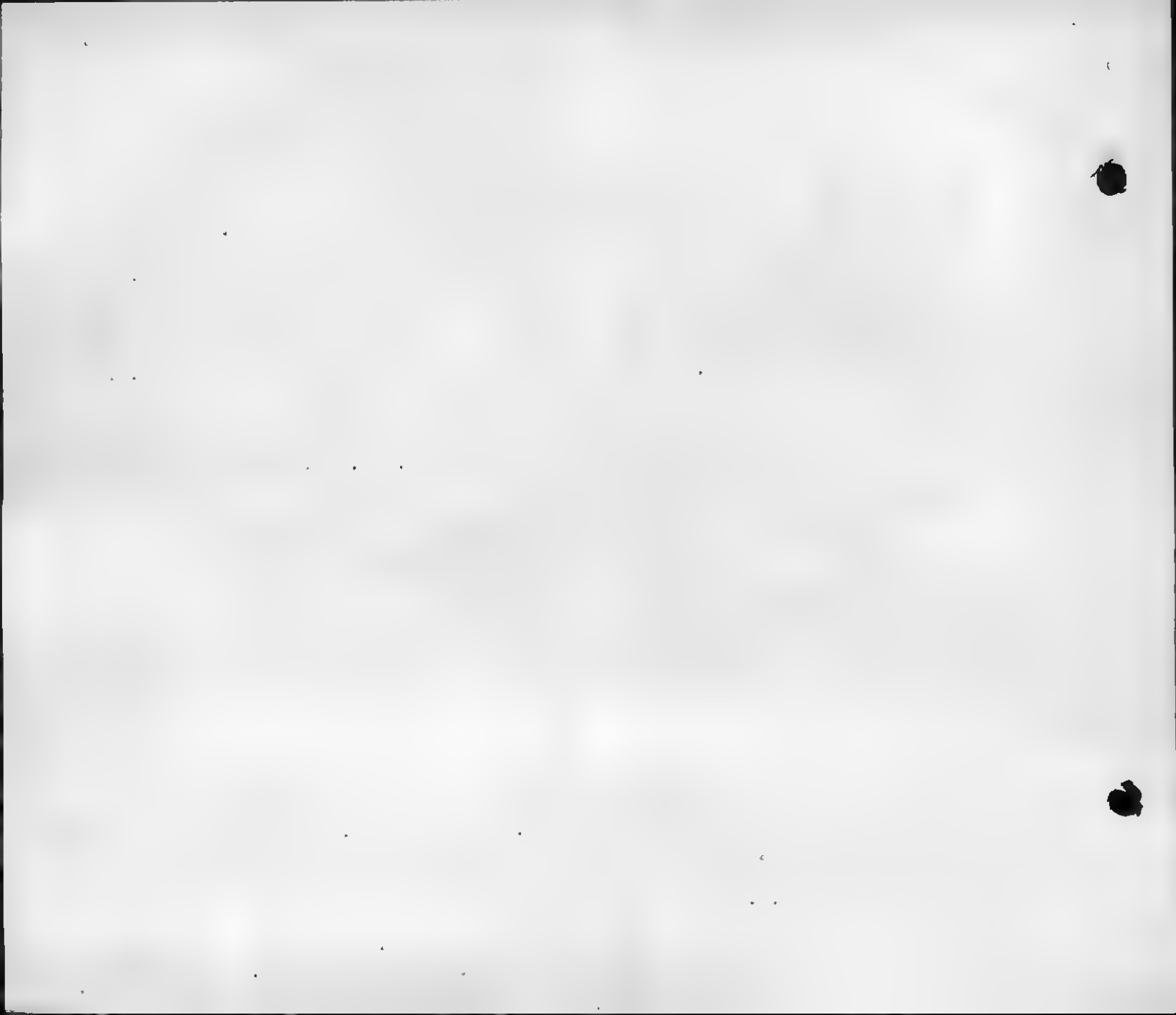
Reg. Dist. No. 4

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) OR FORT HOWARD HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL	MARYLAND LENGTH OF STAY (in this place) 36 DAYS	STATE MARYLAND COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR BALTIMORE STREET ADDRESS (If rural give location) 2400 Cub Hill Rd.	
3. NAME OF DECEASED (First) (Middle) (Last) LOYD (NMI) CHENOWETH		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 15, 1955	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH 1-18-96
9. AGE last birthday 59 yrs		10. BIRTHPLACE (State or foreign country): BALTIMORE, MARYLAND	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Instructor Md/Training School		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN CHENOWETH		14. MOTHER'S MAIDEN NAME: MANNIE FULLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service): WW-I		16. SOCIAL SECURITY NO. 215-30-4314	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 422.1		6 HOURS	
ANTECEDENT CAUSE (S) DUE TO CONGESTIVE HEART FAILURE - ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO PULMONARY EMPHYSEMA			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, etc.) OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from MAR. 10, 1955 , to APR. 15, 1955 , and that death occurred at 7:40 P.M. from the causes and on the date stated above.			
SIGNATURE John A. Surmonte		DATE SIGNED 4-16-55	
NAME OF DECEASED JOHN A. SURMONTE, M.D.		M.D. VAH, FORT HOWARD, MARYLAND	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF APRIL 19 1955	NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEM. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-14-55	REGISTRAR'S SIGNATURE A. W. Hedrick	24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc. Funeral Home ADDRESS 6009 Harford Road, Baltimore 11, Md.	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



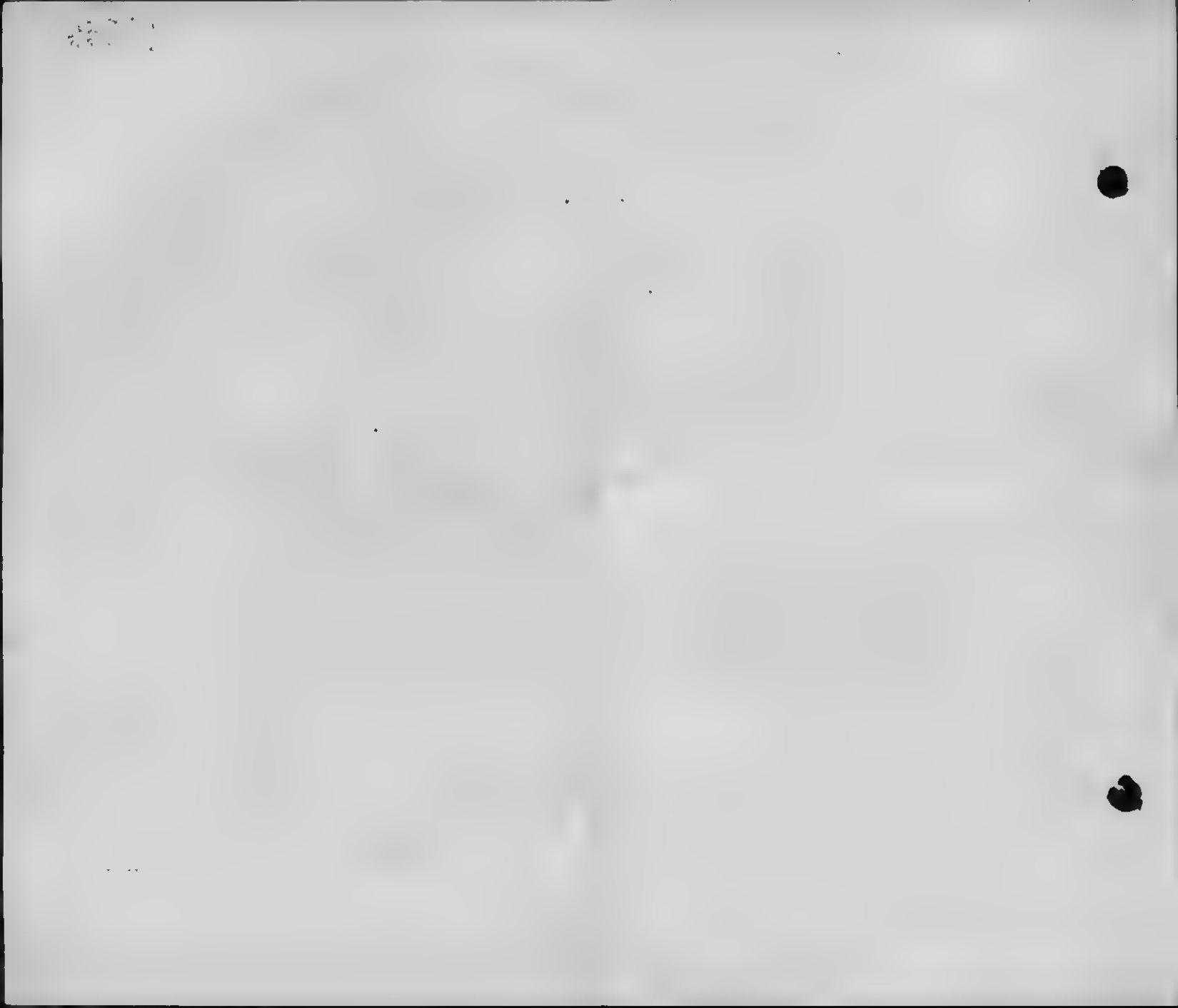
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3394
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03365
 Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>byr. 9 mo. 2 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Baltimore</u> <u>3V01.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural, give location) <u>Seton Institute 1019 E. Hoffman St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>Joseph F. Coffay</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>April 1, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>4-19-1888</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John F. Coffay</u>				14. MOTHER'S MAIDEN NAME: <u>Mary A. Tierney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
437.1 Immediate cause (a) ... <u>Coronary thrombosis</u> DUE TO							
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause (b) stating underlying cause last (c) DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Geo S McKieffer</u>		1010 Leeds on		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> <u>4-1-55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 4-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		LOCATION (City, town, or county) (State) <u>4430 Belair Rd Balto Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 2, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Joseph J. Janssen Inc. 712-74 E. North Ave</u>			



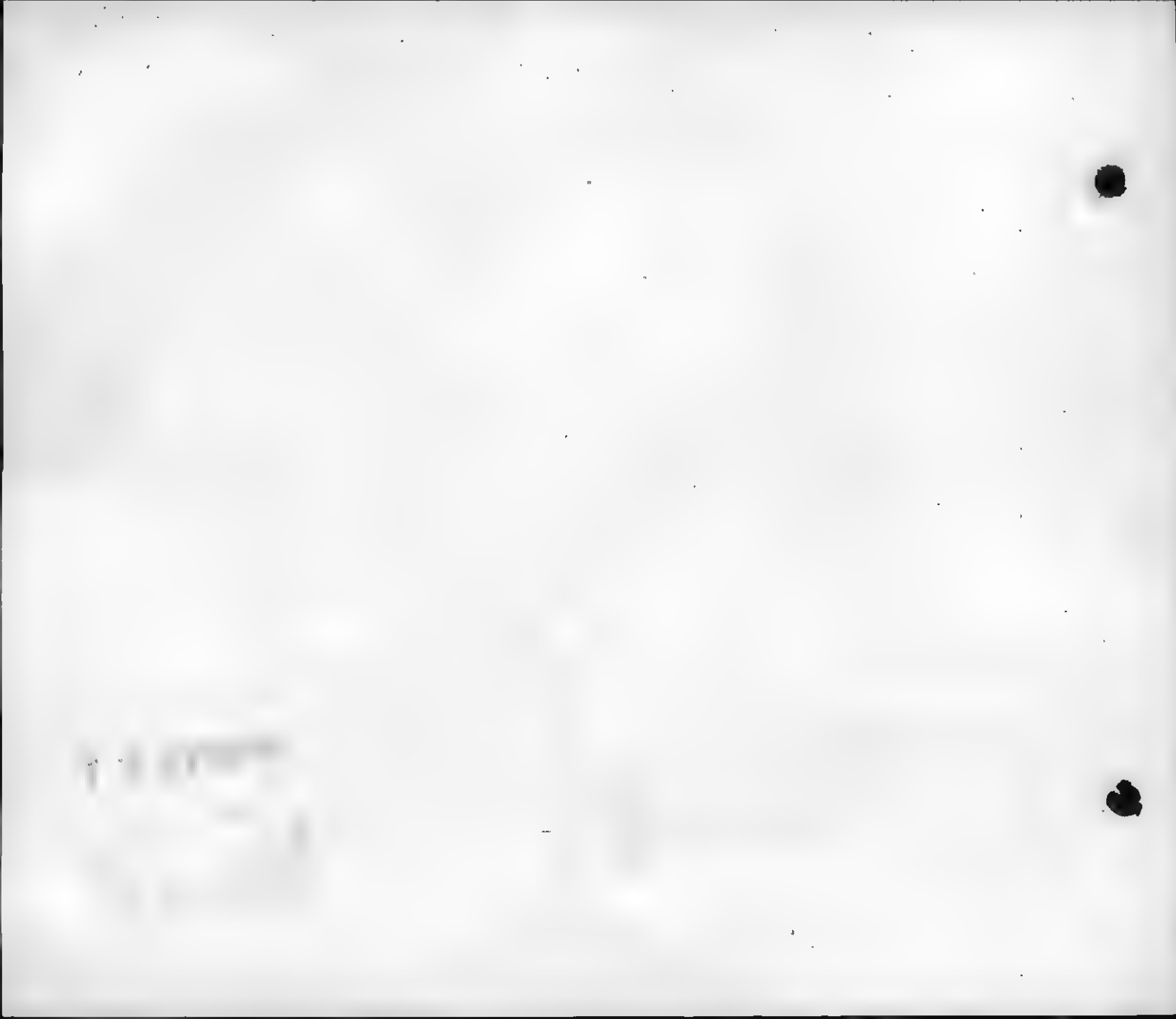
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03366**
3395 **CERTIFICATE OF DEATH**

Reg. Dist. No. **30**

1. PLACE OF DEATH COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dundalk 22, 53 STREET ADDRESS (If rural give location) 8241 Bullneck Road	
3. NAME OF DECEASED: (First) (Middle) (Last) James C. Cook		4. DATE (Month) (Day) (Year) OF DEATH: April 29, 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 2-16-1874
9. AGE last birthday: 81 yrs		10. UNDER 1 YEAR: Months Days Hours Min.	11. AGE last birthday: 81 yrs
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Co.		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Massachusetts
13. FATHER'S NAME: Eugene Cook		14. MOTHER'S MAIDEN NAME: Elizabeth Cook	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): Unknown		16. SOCIAL SECURITY NO.: Unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hosp.		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Bronchopneumonia ANTECEDENT CAUSE (B) Arteriosclerotic cardiovalvular disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH 5 days Years	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 8-9-1954 , to 4-29-1955 , that I last saw the deceased alive on 4-29-1955 , and that death occurred at 11:40 AM from the causes and on the date stated above. SIGNATURE S. Wachsman M. D. Catonsville 28, Maryland Spring Grove State Hospital DATE SIGNED 4-29-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-2-55	
NAME OF CEMETERY OR OPERATOR Post Harvest Funeral Chapel Hagerstown		LOCATION (City or town, or county) (State) 2nd	
DATE REC'D BY LOCAL REGISTRAR APR 30, 1955		REGISTRAR'S SIGNATURE V.E. Harris	
24. FUNERAL DIRECTOR Post Harvest Funeral Chapel Inc		ADDRESS Hagerstown 2nd	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Item 10-11-181 5-18-55 and

3396

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

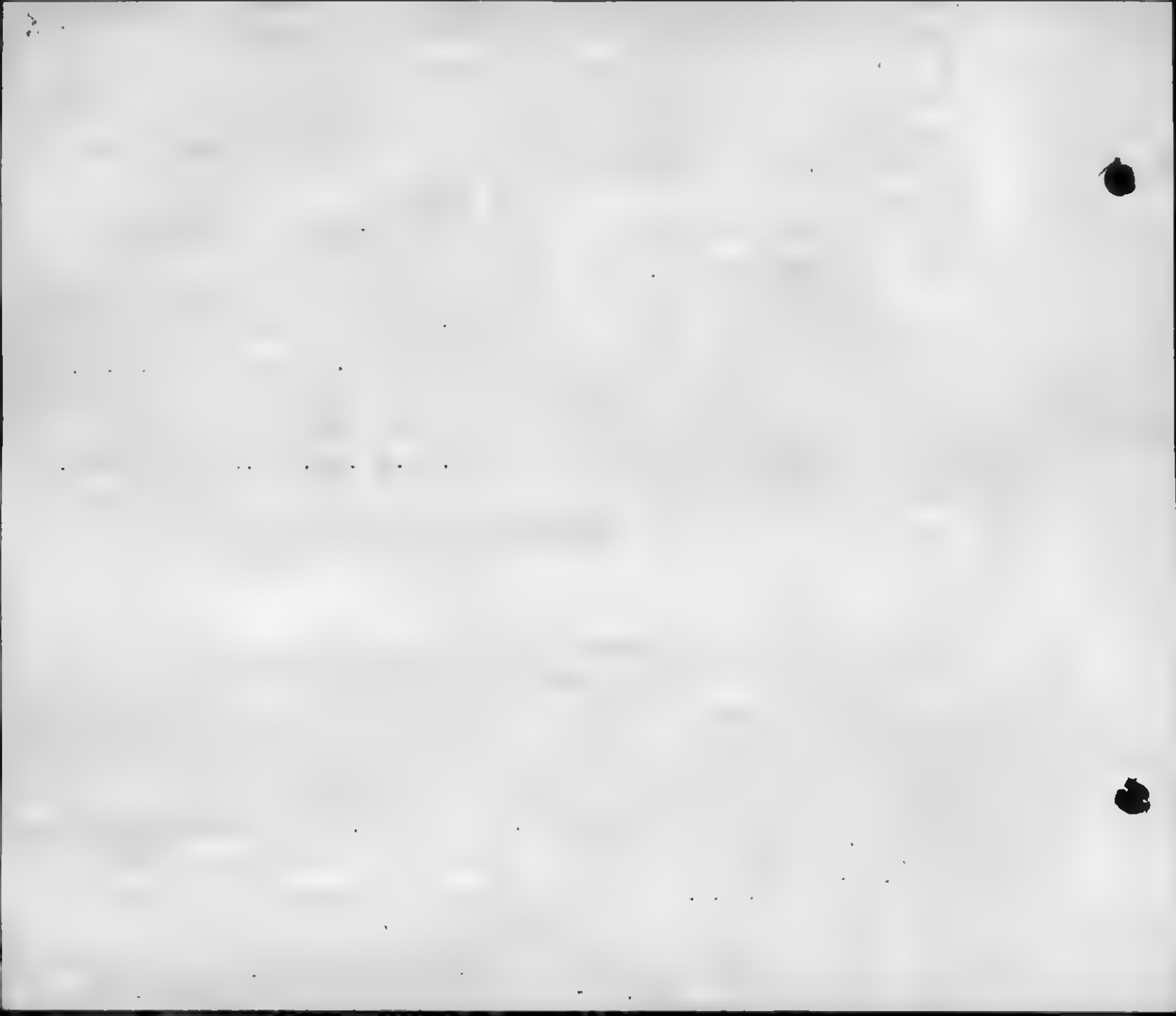
03367

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND COUNTY ALLEGANY	
CITY (If outside corporate limits, write RURAL OR TOWN FORT HOWARD)	LENGTH OF STAY (In this place) 2 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) RT. #1 RED HILL,	
3. NAME OF DECEASED: (First) ROBERT (Middle) D. (Last) COOK		4. DATE (Month) (Day) (Year) OF DEATH APRIL 13 19 55	
5. SEX: male	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: FEBRUARY 22, 1910
9. AGE last birthday 44 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MINER		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): MOOREFIELD, W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: WILLIAM COOK		14. MOTHER'S MAIDEN NAME: JANE LOWDERSHELT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) YES WW II		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FORT HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 082X		DUE TO lymphatic choriomeningitis	
ANTECEDENT CAUSE (B)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO	
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from APR. 11, 19 55 to APR. 13, 19 55 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 4-14-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 14, 19 55	
NAME OF CEMETERY OR CREMATORY FROSTBURG PARK CEMETERY		LOCATION (City, town, or county) FROSTBURG, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR WM. COOK-BLIGHT, INC. FUNERAL HOME		ADDRESS 6009 HARFORD RD., BALTIMORE 11, MD.	

SHIPPED



3397

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MD.	COUNTY BALTIMORE
CITY (If outside corporate limits, write RURAL OR and give nearest town) NORTH BROOK	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NORTHBROOK	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location) 8050 GOUGH ST.	
3. NAME OF DECEASED: (First) (Middle) (Last) NELLIE GRACE CORKRAN		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 15, 1955.	
5. SEX: FEMALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: JULY 1, 1882
9. AGE last birthday: 72 yrs.		10. MONTHS: 72 Months	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY: HOUSEWORK	
11. BIRTHPLACE (State or foreign country): VIENNA, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: T. S. SELLERS.		14. MOTHER'S MAIDEN NAME: GERTRUDE SOLLOWAY.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: JAMES S. CORKRAN SAME.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
1997 IMMEDIATE CAUSE (A) Generalized Carcinomatosis		8 Months	
ANTECEDENT CAUSE (S) (B) Malignancy of Pancreas		4 months	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 2 1955, to April 15 , 1955 that I last saw the deceased alive on April 15, 1955 , and that death occurred at 8:10 A M, from the causes and on the date stated above.			
SIGNATURE Monie G. Jacobs		ADDRESS M.D. 1010 NORTH Point Rd. Bldg 24	
DATE SIGNED 4/16/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 4-18-55	
NAME OF CEMETERY OR CREMATORY BALTIMORE CEM.		LOCATION (City, town, or county) (State) E. NORTH AV. BALTO., MD.	
DATE REC'D BY LOCAL REGISTRAR 4-18-55		REGISTRAR'S SIGNATURE A. W. [Signature]	
24. FUNERAL DIRECTOR Charles S. Geiler		ADDRESS 901 S. CONKLINGS BALTO., MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3398 CERTIFICATE OF DEATH

03369

Reg. Dist. No. 30

1. PLACE OF DEATH: Balto.		2. USUAL RESIDENCE (HOME) OF DECEASED: Md.	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	1-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1 House in the Pines 16 Fusting Avenue		STREET ADDRESS (If rural give location) 35 N. Abington Ave.	✓
3. NAME OF DECEASED: (First) (Middle) (Last) MAMIE E. CRABILL		4. DATE (Month) (Day) (Year) OF DEATH: Apr. 5, 1955	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: May 22, 1881
9. AGE last birthday: 73 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Thomas Toms	
14. MOTHER'S MAIDEN NAME: Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.: 212-03-8527 B		17. INFORMANT & ADDRESS: Mr. S. Durward Crabill - 35 N. Abington Av	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE (A) Pulmonary Edema			1 day
ANTECEDENT CAUSE (B) Cerebral Embolism			3 Mts
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) Hemiplegia			3 Mts
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 4, 1955 , to Apr 5, 1955 , that I last saw the deceased alive on Apr 4, 1955 , and that death occurred at 6:10 P. M. from the causes and on the date stated above.			
SIGNATURE James L. Latzenberger		DATE SIGNED 4/5/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/8/55	
NAME OF CEMETERY OR CREMATORY Lorraine Cem.		LOCATION (City, town, or county) Woodlawn, Md.	
DATE REC'D BY LOCAL REGISTRAR 4-7-55		REGISTRAR'S SIGNATURE A W. H. H. H.	
24. FUNERAL DIRECTOR Wm. J. Tiekner & Sons - Balt.		ADDRESS Baltimore, Md.	



3399

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Owings MillsLENGTH OF STAY
(in this place)2 1/2 yrs.HOSPITAL OR
INSTITUTION ORSTREET ADDRESS Rosewood Training School

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY Howard

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Ellicott City13 X -STREET
ADDRESS

(If rural give location)

390 Main Street3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

David AnthonyCross4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

41019 55

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): single

8. DATE OF BIRTH:

11/1/49

9. AGE last birthday:

5 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired): ---10b. KIND OF BUSINESS OR
INDUSTRY: ---

11. BIRTHPLACE (State or foreign country):

Maryland12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

Vernon Daniel Cross

14. MOTHER'S MAIDEN NAME:

Ramona Ridgley15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service) ---16. SOCIAL SECURITY No.: ---

17. INFORMANT & ADDRESS:

Rosewood Records, Owings Mills, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

921.7
Immediate cause(a) Subacute suffocation due to obstruction of

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) lower airways by aspirated food.

DUE TO

(c)

Interval Between
Onset And Death12 hours

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☒ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/4/52, 1952, to 4/10/55, 1955, that I last saw the deceasedalive on 4/10/55, and that death occurred at 11:55 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. B. ButlerM.D.Owings Mills, Md.4/11/5523. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county) (State)

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

REGISTRAR

4-12-55 Mary B. ElineEaston Bone Catonsville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5 A DAY

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

34-0

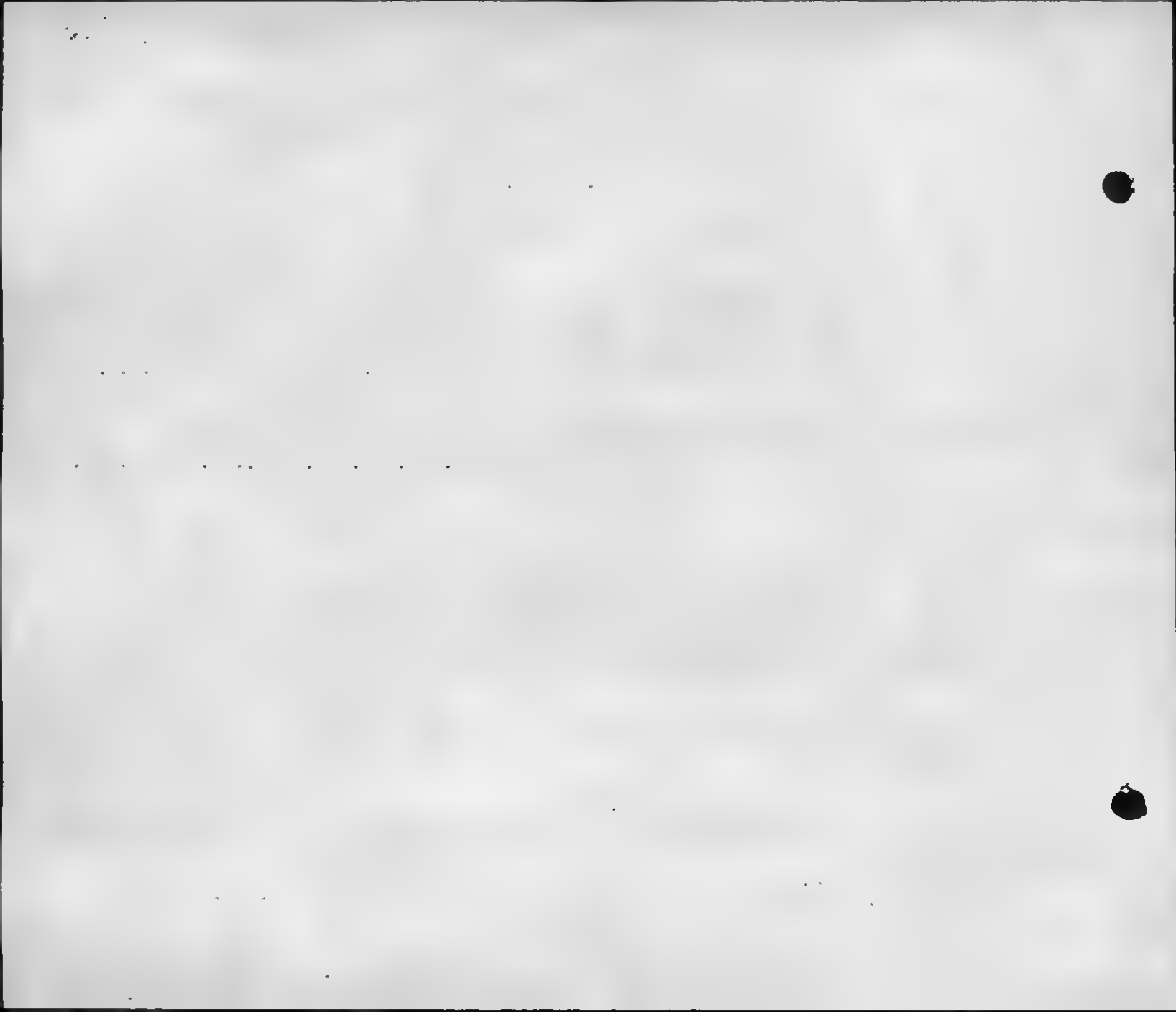
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard</u>		<u>9 Hrs. 5 Min.</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				<u>917 Wilmer Court</u>			
3. NAME OF DECEASED. (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>MARTIN L DAVIS</u>				<u>April 5 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>11/15/92</u>	
9. AGE last birthday <u>62</u> yrs.		10. AGE last birthday IF UNDER 1 YEAR Months Days		11. BIRTHPLACE (State or foreign country): <u>Plainfield, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Steel Mill</u>			
13. FATHER'S NAME: <u>William Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service: <u>Yes WW-I</u>				16. SOCIAL SECURITY NO. <u>212 01 8968</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE, DECOMPENSATED.</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) <u>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 4, 1955</u> to <u>April 5, 1955</u> , and that death occurred at <u>4:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>4/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/8/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-7-55</u>		REGISTRAR'S SIGNATURE <u>W. W. Phillips</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St. Balto. Md.</u>	



MARYLAND

03372
STATE DEPARTMENT OF HEALTH

3401

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 PAYSON AVE.</u>		STREET ADDRESS (If rural, give location) <u>12 PAYSON AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>WILLIAM</u> (Middle) <u>FRANKLIN</u> (Last) <u>DAVIS</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>OCT. 13, 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLER</u>	
10b. KIND OF BUSINESS <u>DOUGHNUT MILL</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>ROBERT DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>ISABEL KEYS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>160-160-160</u>	
17. INFORMANT AND ADDRESS <u>Wm. Roger Davis - 160 Second Ave.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> Antecedent cause(s) <u>Hypertension</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 1950</u> to <u>4/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/5</u> , 19 <u>55</u> , and that death occurred at <u>7:45 P</u> m., from the causes and on the date stated above.		DATE SIGNED <u>4/12/55</u>	
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>Catonville, Md.</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>	
DATE <u>4-12-55</u>		LOCATION (City, town, or county) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/12/55</u>		24. FUNERAL DIRECTOR <u>Julius T. [Signature]</u>	
REGISTRAR'S SIGNATURE <u>V.G. Harry</u>		ADDRESS <u>Home, Catonsville, Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03373

CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY _____
CITY (If outside corporate limits, write RURAL) _____	LENGTH OF STAY (in this place) 40 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) _____	
<input checked="" type="checkbox"/> TOWN FORT HOWARD		OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 7319 HOLABIRD AVE.	
3. NAME OF DECEASED: (First) CHARLES (Middle) S. (Last) DEAVER		4. DATE (Month) (Day) (Year) OF DEATH: APRIL 13 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH: 8-12-77
9. AGE last birthday 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asbestos Worker PIPE COVERING	
11. BIRTHPLACE (State or foreign country): MORRISTOWN, N.J.		12. CITIZEN OF WHAT COUNTRY: U.S.A.	
13. FATHER'S NAME: JOHN DEAVER		14. MOTHER'S MAIDEN NAME: HESTER (MAIDEN NAME UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) YES SAW		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) HYPERTENSIVE CARDIOVASCULAR DISEASE		UNKNOWN	
ANTECEDENT CAUSE (S) _____			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. _____			
19A. DATE OF OPERATION: _____		19B. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? _____			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from MARCH 4, 1955 , to APRIL 13, 1955 , and that death occurred at 9.05A.M. from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M.D. VAH, FORT HOWARD, MARYLAND 4-14-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF APRIL 15 1955	
NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		LOCATION (City, town, or county) BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR 4-14-55		REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR WM. COOK-BLIGHT, INC. FUNERAL HOME		ADDRESS 6009 HARFORD RD. BALTIMORE 11, MD.	



3353

03374

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 1

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Donnalic</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Gray Manor</u>	TOWN <u>Gray Manor</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2610 Ambler Road</u>		STREET ADDRESS (If rural, give location) <u>2610 Ambler Road</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>LILLIAN</u>	(Middle)	(Last) <u>Dietrich</u>	(Month) <u>Apr.</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 22, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	9. AGE last birthday: <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Peter Fooks</u>		14. MOTHER'S MAIDEN NAME: <u>Katherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
		17. INFORMANT & ADDRESS: <u>George L. Dietrich 2610 Ambler Road</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a)..... <u>Coronary Occlusion</u>			
DUE TO			
Antecedent cause(s) (b).....			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/8/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL, (Specify): <u>Burial</u>	DATE THEREOF <u>April 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Schwartz's</u>	LOCATION (City, town, or county) (State) <u>Baltimore</u>
DATE REC'D BY LOCAL REG. <u>4-11-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR ADDRESS <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



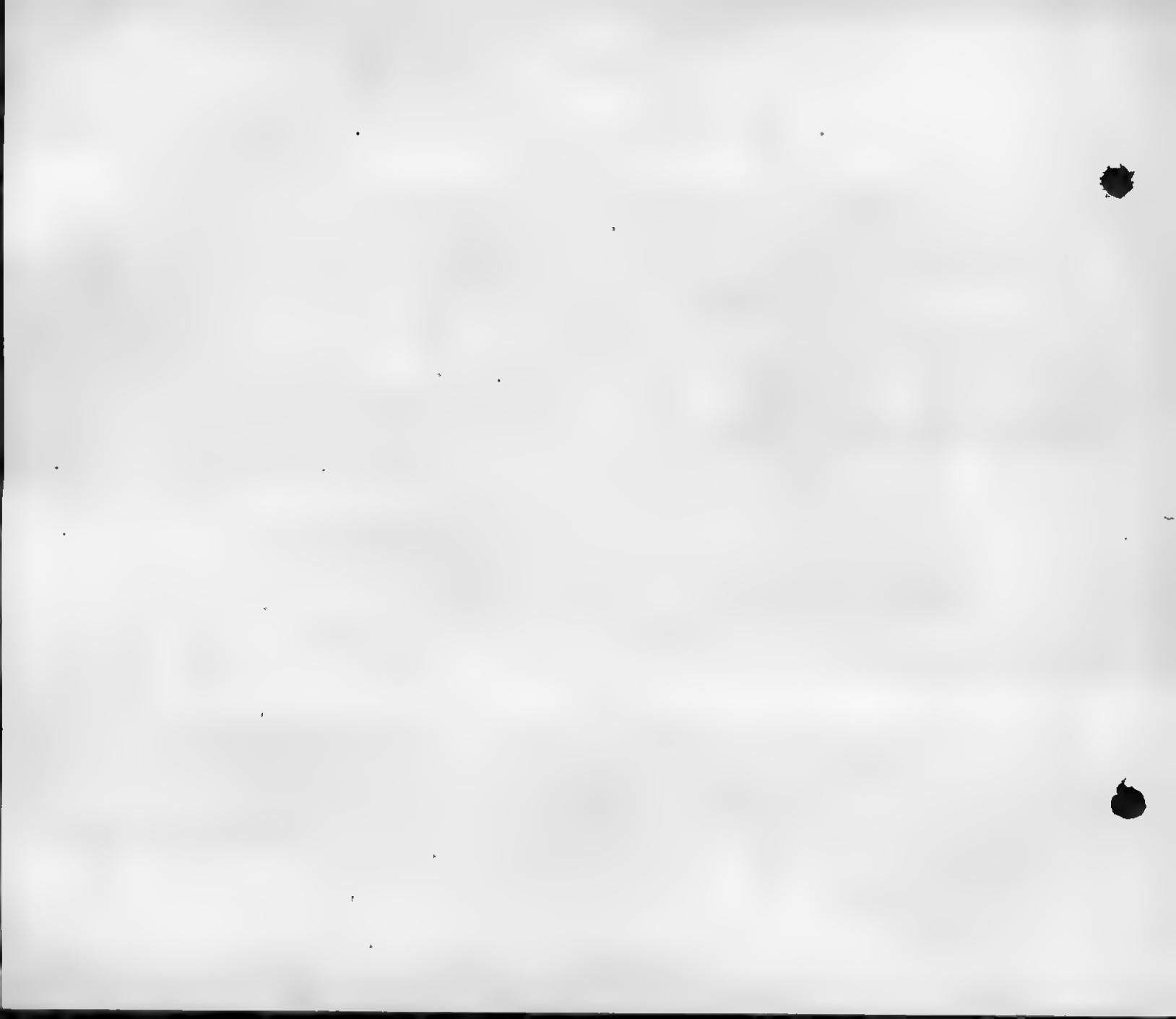
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3401.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Ridgeway Nursing Home 5743 Edmondson Ave.</u>		STREET ADDRESS (If rural give location) <u>522 Rock Glen Rd.</u>	
3. NAME OF DECEASED: (Type or Print) <u>LOUISE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 27 19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 31, 1873</u>
10A. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired: <u>never worked</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <u>Frederick A. Kaupp</u>		14. MOTHER'S MAIDEN NAME: <u>Justine Kleinherm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO <u>no</u>	
17. INFORMANT & ADDRESS: <u>Miss Justine C. Dashner-526 Swann Ave.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.0</u>			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Arteriosclerotic Heart Disease</u>		2 yrs.	
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Carcinoma of Stomach</u>		4 month	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>53</u> , to <u>April 27 19 55</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>55</u> and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>For J. Gava</u>		DATE SIGNED <u>4/27/55</u>	
23. BURIAL CREMATION REMOVAL (SPECIFY) <u>Removal-Burial</u>		DATE THEREOF <u>4/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/28/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

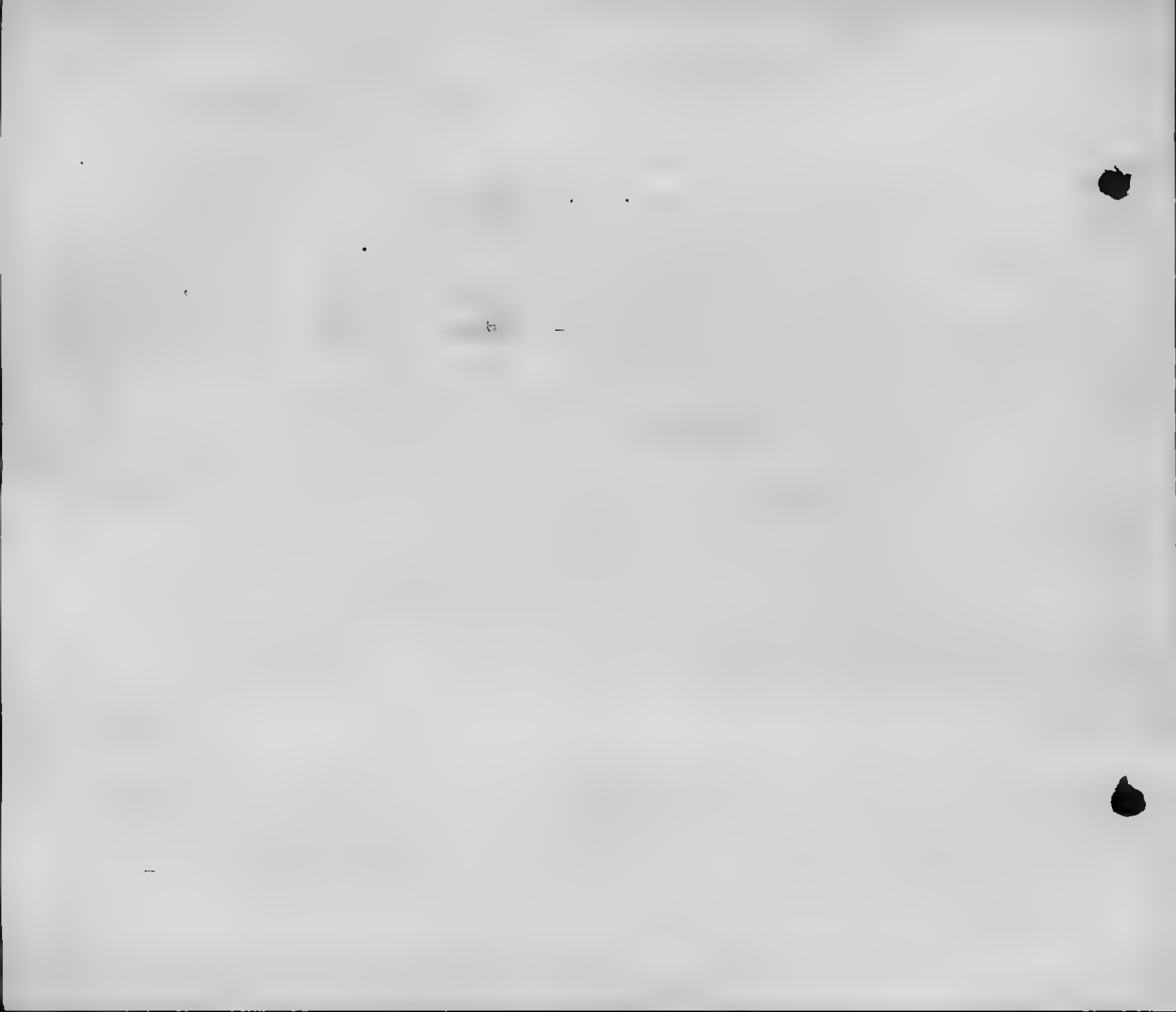


PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: leave write the cause of death clearly and legibly.

3404
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 03376

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>18yr. 2mo. 1 day</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Baltimore</u>		<u>3404</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural, give location) <u>707 S. Decker Avenue</u> ✓			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Pauline</u>		(Middle)		(Last) <u>Blugoborska</u>		(Month) (Day) (Year) <u>April 25, 1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>1-26-1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: <u>63</u> yrs.		11. BIRTHPLACE (State or foreign country): <u>Poland</u>	
13. FATHER'S NAME: <u>Alexander Redyk</u>				12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> ✓			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				14. MOTHER'S MAIDEN NAME: <u>Victoria ?</u>		17. INFORMANT & ADDRESS: <u>Unknown Records Spring Grove State Hospital</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary thrombosis</u> DUE TO Antecedent cause(s) (b) <u>Arteriosclerotic cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Years</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Mental Illness</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Herb M. Kieffer</u>		1010 <u>Ludman</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-25-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REG. <u>Apr 27, 1955</u>		REGISTRAR'S SIGNATURE <u>H. W. Nedzick</u>		24. FUNERAL DIRECTOR <u>Fred W. Ozazewski</u>		ADDRESS <u>1930 Eastern Ave</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03377

3405

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> TOWN <u>Lutherville</u> LENGTH OF STAY (in this place) <u>2 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bellona Ave</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville</u> STREET ADDRESS (If rural give location) <u>Bellona Ave</u>	
3. NAME OF DECEASED: (First) <u>Cassandra</u> (Middle) <u>Dorsey</u> (Last) <u>Dorsey</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 6 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>18 June 1880</u>
9. AGE last birthday <u>74</u> yrs		10. UNDER 1 YEAR: Months Days	11. UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country): <u>Hartford Co., Md</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>William Henry Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Edsabeth Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-32-1171</u>	
17. INFORMANT & ADDRESS: <u>Daughter - Sarah C. Williams Towson Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE (B) <u>Hypertensive Arteriosclerotic CV Disease</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours over 8 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 1954</u> to <u>6 April 1955</u> , that I last saw the deceased alive on <u>31 March 1955</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Walter T. Kees</u> ADDRESS <u>Cockeysville, Md.</u> DATE SIGNED <u>6 April 1955</u>			
23 BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 9, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Pleasant Rest</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>R. W.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Holland Funeral Home - 1631 David Hill Ave.</u>	



3406

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH:

COUNTY

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

54

TOWN

LENGTH OF STAY
(in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

54

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

90

Villa Nova, Balto

STREET (If rural give location)
ADDRESS

Essex Rd. Balto 7, Md.

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

Rertie

Estelle

Dunn

4. DATE (Month)
OF (Day) (Year)

April 19

19 55

5. SEX:
F6. COLOR OR
RACE:7. SINGLE. MARRIED.
WIDOWED, DIVORCED,
(Specify): Widow8. DATE OF BIRTH:
6-15-829. AGE last birthday
72 yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.

11. IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired): Housewife10B. KIND OF BUSINESS
OR INDUSTRY:11. BIRTHPLACE (State or foreign country):
Baltimore, Md.12. CITIZEN OF WHAT
COUNTRY?
U.S.

13. FATHER'S NAME:

Allen (first name unknown)

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service)

No

16. SOCIAL SECURITY No.

17. INFORMANT & ADDRESS:

Son 3526 Essex Rd. Balto 7, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (B)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.INTERVAL BETWEEN
ONSET AND DEATH

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF "INJURY"21E. INJURY OCCURRED
While ☐ Not while ☐
at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15, 1955, to 4/19, 1955, that I last saw the deceased

alive on 4/16, 1955, and that death occurred at 4:00 P.M. from the causes and on the date stated above.

SIGNATURE

Edwin G. Simpson

M. D.

ADDRESS: 1011 10th St. DATE SIGNED 4-1-55

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

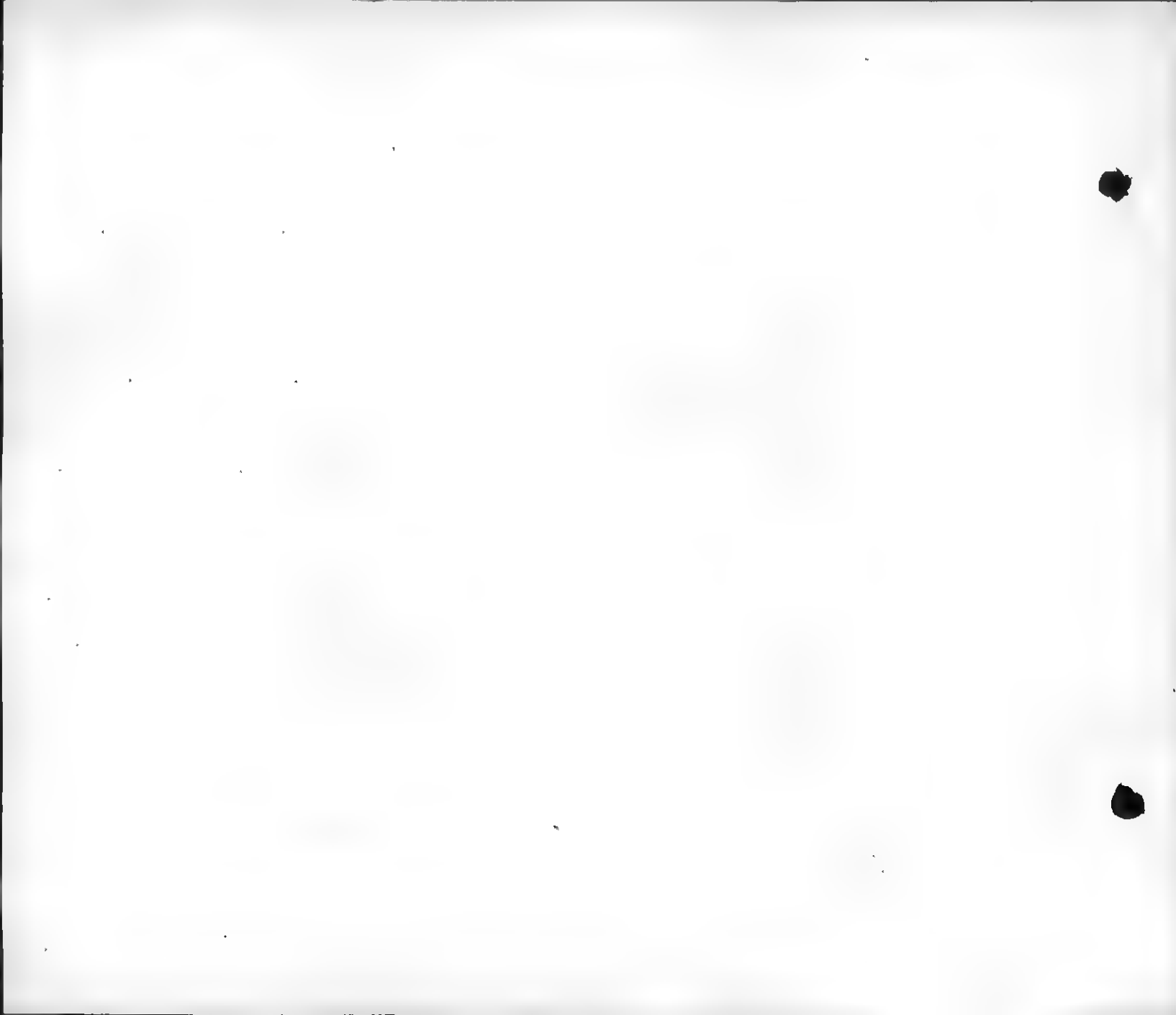
4-20-55

a w Hedrick

Loring Byers

5205 Pleasant St. Balto 15, Md.

MARGIN RESERVED FOR BINDING

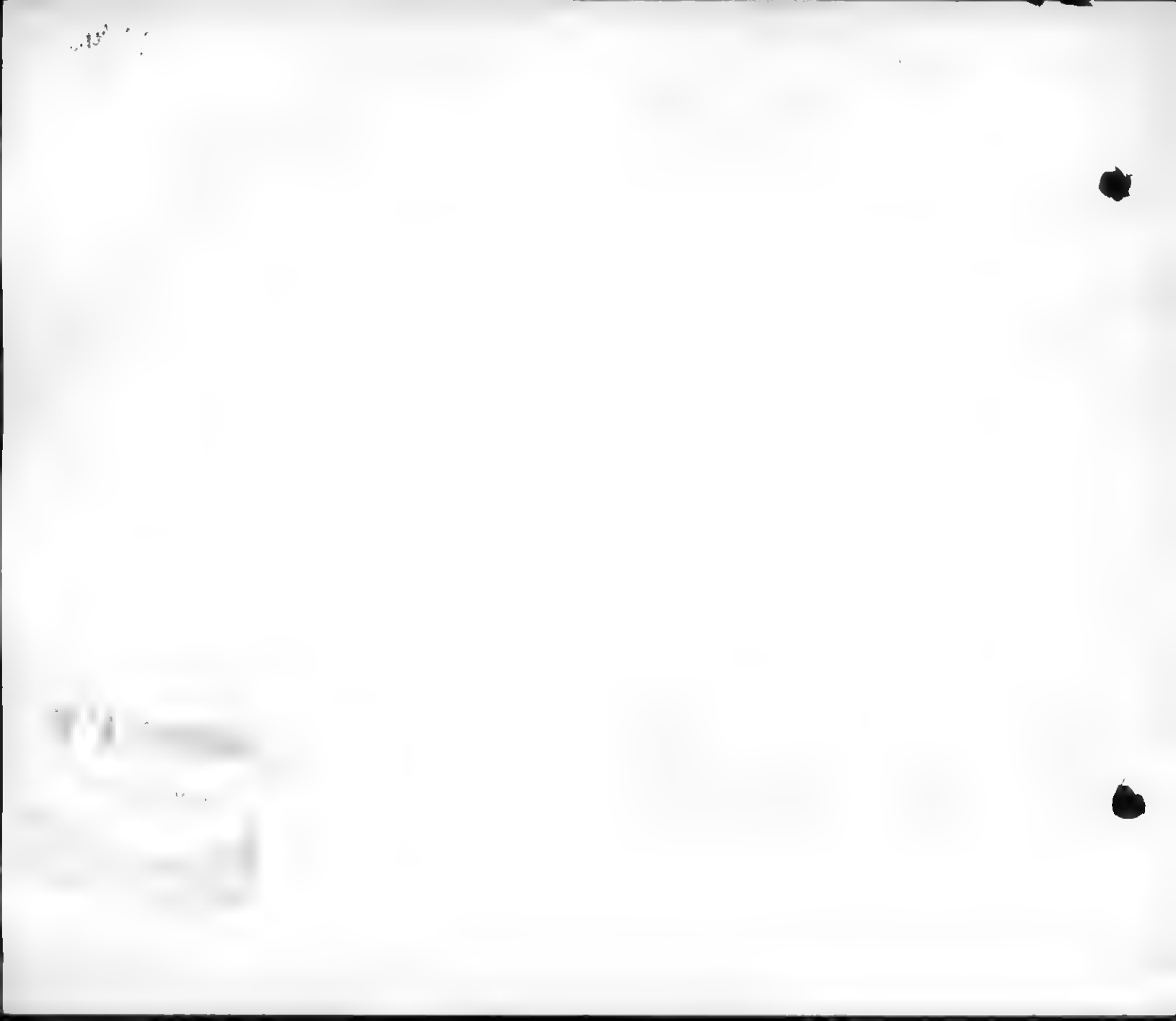


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03379**
3497 **CERTIFICATE OF DEATH**

Reg. Dist. No. **21**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore Co.</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Granite</u>		<u>37 yrs.</u>		<u>Granite</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u> <u>Davis Avenue</u>				<u>Davis Avenue</u>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<u>GEORGE</u>		<u>A.</u>		<u>ELLWOOD</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Dec. ? 1879</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday		4. DATE (Month) (Day) (Year) OF DEATH: <u>Apr. 5th., 1955</u>	
<u>Employed Farmer</u>		<u>Dairy Herd</u>		<u>75 yrs.</u>		<u>Months</u> <u>Days</u> <u>Hours</u> <u>Mtn.</u>	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Washington D. C.</u>				<u>U. S. A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Unknown</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
<u>No</u>				<u>NONE</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>Mrs. Anna Ellwood Davis Ave. Granite, Md.</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
422.1 IMMEDIATE CAUSE				<u>1 day</u>			
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebral hemorrhage</u>							
DUE TO							
(B) <u>Cardio Vascular Disease</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/5/55</u> , 1955, to <u>4/5/55</u> , 1955, that I last saw the deceased alive on <u>4/5/55</u> , 1955, and that death occurred at <u>11:12</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Wm. E. Martin</u>		ADDRESS <u>Pandalltown Md</u>		DATE SIGNED <u>4/6/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/8/55</u>		<u>St. Marys Cemetery</u>		<u>Laurel, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/6/55</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>		24. FUNERAL DIRECTOR <u>E. Eaton Rome</u>		ADDRESS <u>Catonsville, Md.</u>	



29-53

3408

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03380

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 9, Film G180 4-18-55 et

1 PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND CITY (If rural, write RURAL, and give nearest town) <u>Catonsville</u> OR <u>2 days</u> LENGTH OF STAY (in this place) TOWN <u>Spring Grove State Hosp.</u>		2 USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>A.A.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> OR <u>02X 2</u> TOWN <u>5th Ave</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED. (Type or Print) <u>Mattie M. Elswick</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>4-8-1955</u>	
5. SEX <u>F</u> 6 CO OP OR 7 SINGLE MARRIED, <u>W</u> DOWED DIVORCED <u>W</u> RAFE <u>W</u>		8 DATE OF BIRTH <u>9-19-1880</u> 9. AGE last birthday <u>74</u> <u>71st</u> yrs Months Days Hours Min.	
10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Unemployed</u>		10B KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <u>Ohio</u>		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME: <u>Abraham Moore</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Brammer</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17 INFORMANT & ADDRESS <u>Mrs Henry Siegart, Pasadena, Md</u>	
18. MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>434.2</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(A) <u>Pulmonary Edema</u> DUE TO (B) <u>Cardiac failure</u> DUE TO (C)	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		21B PLACE (Home, farm, factory OF INJURY street, office bldg., etc	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. HOW DID INJURY OCCUR?	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M</u>		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>4-7</u> , 1955, to <u>4-8</u> , 1955, that I last saw the deceased alive on <u>4-8</u> , 1955, and that death occurred at <u>7:30</u> M., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS <u>4 8-55</u> DATE SIGNED			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE REC'D BY LOCAL REGISTRAR <u>4/13/55</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> LOCATION <u>Glen Burnie, Md</u>	
24. FUNERAL DIRECTOR <u>Hopping & KIRKLEY</u>		ADDRESS <u>Glen Burnie, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 -- 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3409

CERTIFICATE OF DEATH

Reg. Dist. No. 33~

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkton</u>	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Parkton</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main St.</u>	LENGTH OF STAY (in this place) <u>2 yrs.</u>	STREET ADDRESS (If rural give location) <u>Main St.</u>	
3. NAME OF DECEASED: (First) <u>Margaret</u> (Middle) <u>Ensor</u> (Last) <u>Ensor</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 23, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Jan 6, 1873</u>
9. AGE last birthday <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Lorraine, Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank Mackert</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Mrs Gertrude Boier, Parkton Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>			
ANTECEDENT CAUSE (B) <u>442X</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Due to</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> , to <u>4/23/55</u> , that I last saw the deceased alive on <u>4/23/55</u> , 19 <u>55</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>M. France</u>		DATE SIGNED <u>9/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 26, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>MonktonMeth Cem.</u>		LOCATION (City, town, or county) (State) <u>Monkton, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/27/55</u>		REGISTRAR'S SIGNATURE <u>Mrs Howard S. Marklin</u>	
FUNERAL DIRECTOR <u>Paul Hartenstein</u>		ADDRESS <u>New Freedom, Pa</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1998

2 111

1990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3410				03382			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN CATONSVILLE		12 HRS.		TOWN HAURE DE GRACE 12x 2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS SPRING GROVE HOSP. CATONSVILLE 28, MD.				STREET ADDRESS (If rural, give location) ROUTE #2 ✓			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) NELLIE		(Middle) BENNETT		(Last) EPSTEIN		(Month) (Day) (Year) APRIL 3 19 55	
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M		8. DATE OF BIRTH: UNK.	
9. AGE last birthday: 39 yrs.		10. UNDER 1 YEAR		11. UNDER 24 HRS.		12. MONTHS DAYS HOURS MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): UNK				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): UNK.	
13. FATHER'S NAME: UNK				14. MOTHER'S MAIDEN NAME: UNK.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) UNK.				16. SOCIAL SECURITY No.: UNK.			
17. INFORMANT & ADDRESS: FRED BENNETT ROUTE #2 HAURE DE GRACE MD.							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
334x Immediate cause (a) DUE TO Decubital Pneumonia							
Antecedent cause(s) (b) DUE TO Oedema of the Brain							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 3-31-55 took 22 grs nembutal never regained consciousness							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Dr. M. Kieffer		1010 Leade		CHIEF MEDICAL EXAMINER		DATE SIGNED April 3 55	
DEPUTY MEDICAL EXAMINER		M. D.		ASSISTANT MEDICAL EXAM			
23. BURIAL, CREMATION, REMOVAL (Specify): burial		DATE, TIME OF 4/4/55		NAME OF CEMETERY, OR CREMATORY Woodland cemetery		LOCATION (City, town, or county) (State) Forrestville 10 Md.	
DATE REC'D. BY LOCAL REG. 4/3/55		REGISTRAR'S SIGNATURE V.E. Harry		24. FUNERAL DIRECTOR R. Madison		ADDRESS Forrestville 10 Md.	



3411

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>57 Catonsville</u>	LENGTH OF STAY (Specify this place) <u>8/24/54</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore #23</u>	<u>34.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>	STREET ADDRESS (If rural give location) <u>1425 Ms Henry St.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Sam - Evans</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>4 11 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>m.</u>	8. DATE OF BIRTH: <u>2.8.1888</u>
9. AGE last birthday: <u>67</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>unk.</u>	
11. BIRTHPLACE (State or foreign country): <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY: <u>unknown</u>	
13. FATHER'S NAME: <u>Yreta Evans</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and (unk.)) (If Yes, give war or dates of service) <u>unk.</u>		16. TOTAL NUMBER OF YEARS IN U.S. ARMED FORCES: <u>19.09.1900A</u>	
17. INFORMANT & ADDRESS: <u>This Hospital's Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
423.0 IMMEDIATE CAUSE		(A) <u>Coronary heart vessel, occlusion</u> <u>unknown</u>	
ANTECEDENT CAUSE (B)		(B) <u>arteriosclerotic heart disease</u> <u>per year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Generalized arteriosclerosis</u> <u>few years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/24</u> , 19 <u>54</u> , to <u>4/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/10</u> , 19 <u>55</u> , and that death occurred at <u>6:20 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskas</u>		ADDRESS <u>M.D. Spring Grove St. Hosp.</u> DATE SIGNED <u>4/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>4/13/55</u>	<u>Landon Park</u>	<u>Baltimore</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR'S ADDRESS	
<u>4-12-55</u>	<u>Dr. Hedrick</u>	<u>1011 E. B.M. Walters</u>	
<u>Swine Road & Buckles St.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



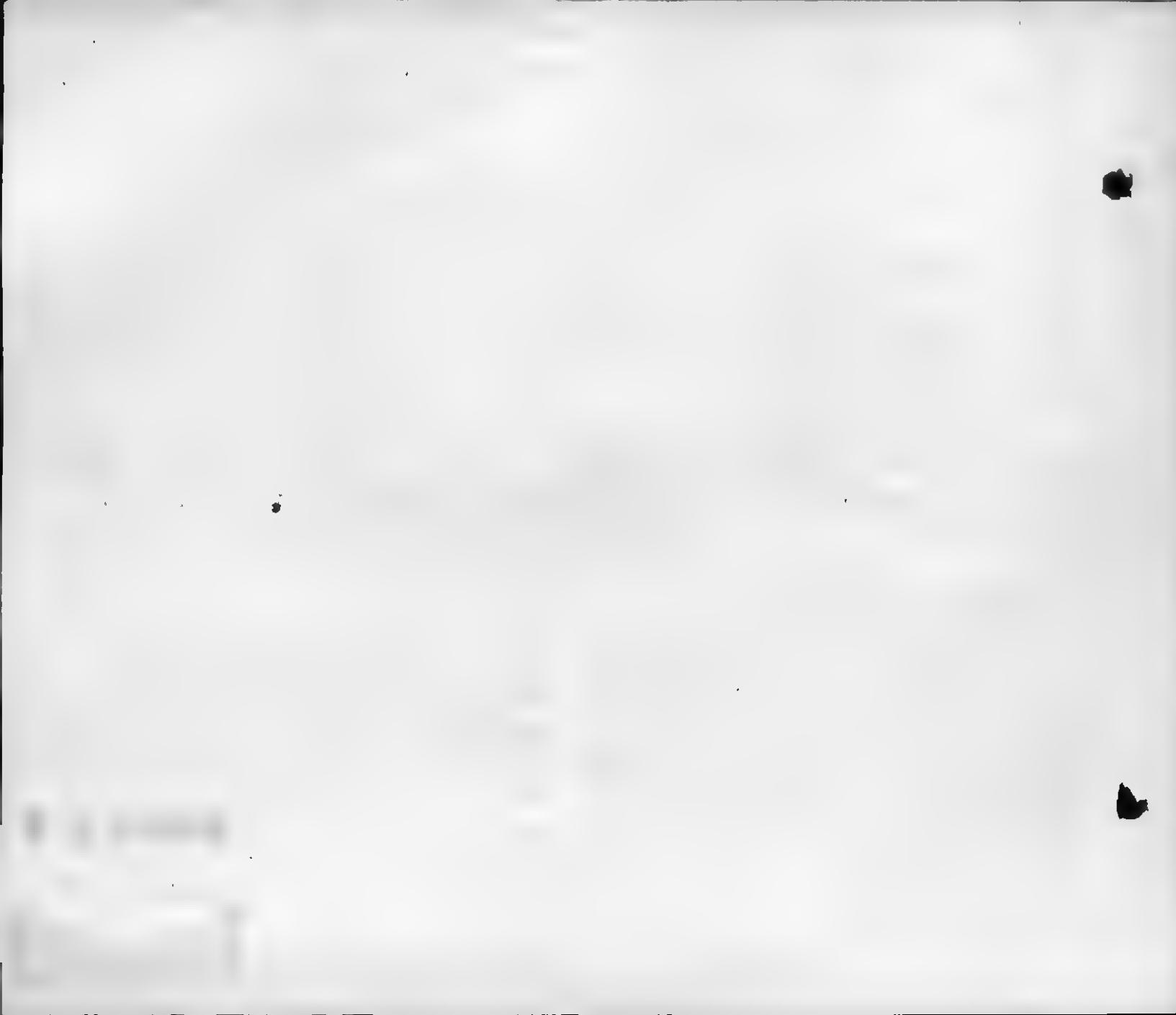
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03384
3412 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Catonsville</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	MARYLAND LENGTH OF STAY (in this place) <u>5 mo. 18 days</u>	STATE <u>Maryland</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>North Beach</u> TOWN STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED. (Type or Print) <u>Edward B Finch</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 1, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12-13-1883</u>
9. AGE last birthday <u>71</u> yrs		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Elevator constructor</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Finch</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Pitnam</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>5910</u>			
IMMEDIATE CAUSE		(A) <u>Diffuse nodular cirrhosis of liver</u> Years	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u> Years			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>10-14-, 1954</u> to <u>4-1-, 1955</u> that I last saw the deceased alive on <u>4-1-, 1955</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/4/55</u>	
NAME OF CEMETERY <u>Mt. Olivet Cemetery</u>		LOCATION <u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/2/55</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	
24. FUNERAL DIRECTOR <u>T. F. Costello</u>		ADDRESS <u>1722 - N. Capital St. Wash. D. C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03385

3413

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY 15	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bowleys Quarters		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bowleys Quarters	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Box 291C Route 15				STREET ADDRESS (If rural, give location) Box 291C Route 15 Baltimore 20	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Alfred		W.	Fischer		April 15 1955
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Nov 29, 1899	9. AGE last birthday 55 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool and Die Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Jacob Fischer		14. MOTHER'S MAIDEN NAME Maria Ertel		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS Mrs Frances Fischer Bowleys Quarters, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

2001
Immediate cause

(a)

Lymphosarcoma of lung

Antecedent cause(s)

(b)

Metastases

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/9 1954, to present 1955, that I last saw the deceased

alive on 4/12 1955, and that death occurred at 9 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-18-55

AW Hedrick

Lilly & Zeiler Inc., 403 S. Wolfe St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3414

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1 PLACE OF DEATH:				2 USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
X TOWN <u>RURAL</u> <u>BALTIMORE</u>				TOWN <u>ECCLESTON</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MERCY VILLA BELONA, AVE.</u>				STREET ADDRESS "THE CAVES"			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>KATHARINE LEMOYNE FISHER</u>				<u>APRIL 26 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>SEPT. 19 1866</u>	9. AGE last birthday: <u>88</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>JOHN VALCOULON LEMOYNE</u>				14. MOTHER'S MAIDEN NAME: <u>JULIA MURRAY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>D.R.A.M. FISHER, RUXTON, 5 MD. BOX 105</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
355X Immediate cause (a) ... DUE TO						?	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ... DUE TO						?	
(c)						?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> to <u>Apr. 25 1955</u> , that I last saw the deceased <u>Apr. 25, 1955</u> , and that death occurred at <u>Mercy Villa, Balto. Co. 4:30 A.M.</u> from the causes and on the date stated above.							
alive on SIGNATURE <u>A. W. Jenkins</u> M.D.		(Degree or title)		ADDRESS <u>18 E. Eager St. Balto.</u>		DATE SIGNED <u>4/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>CREMATION</u>		<u>APR. 26 1955</u>		<u>GREENMOUNT</u>		<u>BALTO. MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-28-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR <u>A. W. JENKINS & SONS CO.</u>		ADDRESS <u>4905 YORK ROAD BALTO. 12 MD</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

03387

MARYLAND STATE DEPARTMENT OF HEALTH

3354

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

41
32

1. PLACE OF DEATH - COUNTY <u>BALTO</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>BALTO</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - PATESVILLE</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>HOLY ROSARY CEMETERY</u>				STREET ADDRESS (If rural, give location) <u>1016 VILHA NOVAK, VILHANOKA</u>			
3. NAME OF DECEASED (Type or Print) <u>HERMAN</u>		(First) <u>W.</u>		(Middle) <u>FLERLAGE</u>		(Last)	
4. DATE OF DEATH <u>4-20-55</u>		5. AGE last birthday <u>76</u> yrs.		6. DATE OF BIRTH <u>MARCH 1879</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	
8. SEX <u>Male</u>		9. COLOR OR RACE <u>White</u>		10. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		13. KIND OF BUSINESS OR INDUSTRY		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
15. FATHER'S NAME <u>WILLIAM FLERLAGE</u>		16. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY No. <u>705-07-9227</u>	
19. INFORMANT AND ADDRESS <u>THEODORE FLERLAGE</u>							

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>420.1</u>			
Antecedent cause(s) (b) <u>Coronary Circulation</u>			
Disease or condition, if any, giving rise to the above cause stating the underlying cause last (c)			

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY?	
Conditions contributing to the death but not related to the disease or condition causing death		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION <u>4/20/55</u>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR	

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE <u>Dr. J. M. Kelly</u>		DATE SIGNED <u>4/20/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>B. 1146</u>		DATE THEREOF <u>APRIL 23, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>HOLY ROSARY</u>		LOCATION (City, town, or county) <u>DUNDALK</u>	
DATE REC'D BY LOCAL REG. <u>4/27/55</u>		REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>	
		24. FUNERAL DIRECTOR ADDRESS <u>1160 E. 11th St. PATESVILLE</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDWARD V. S.

1934

1934

3415

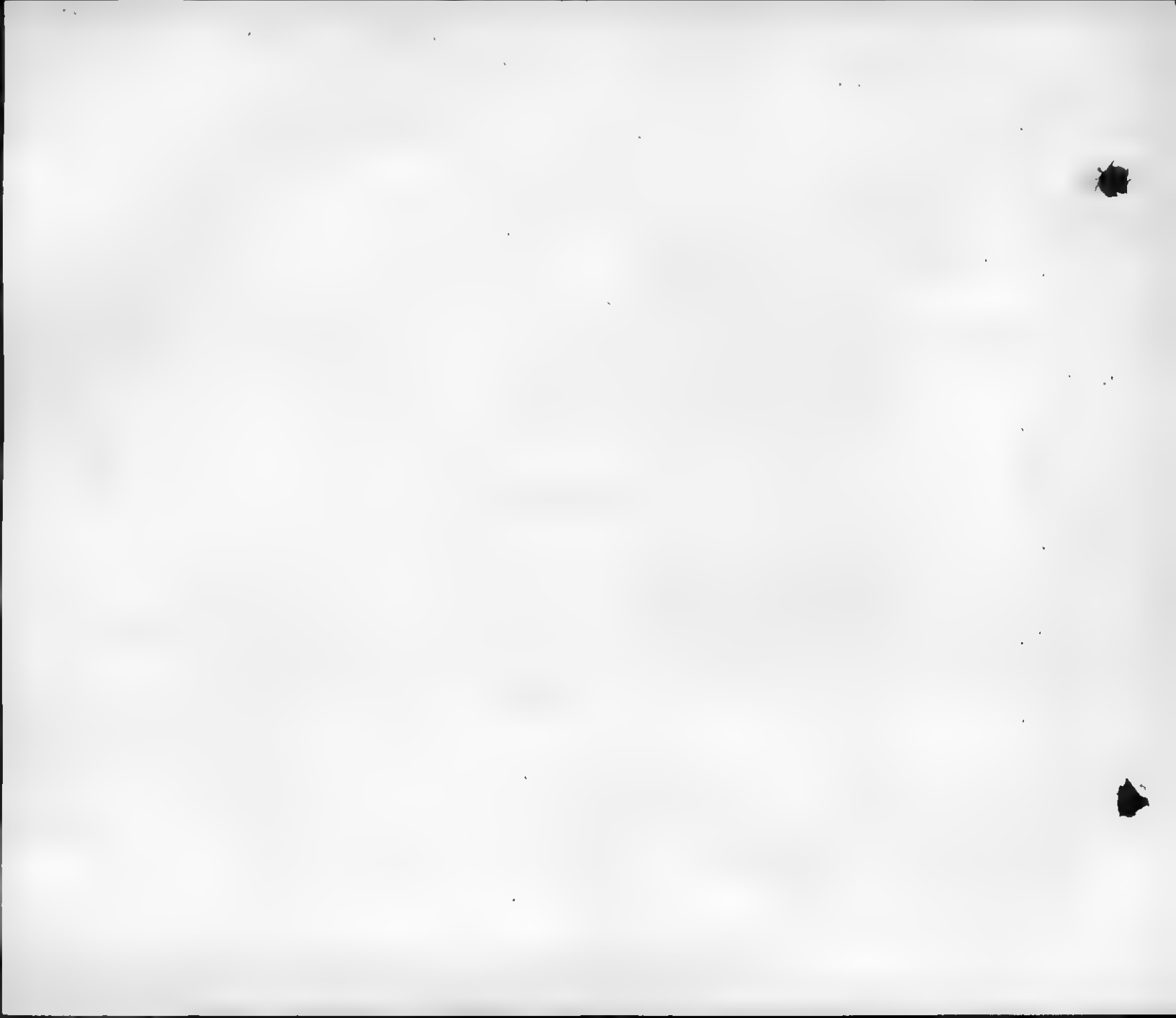
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>5220 Catonsville</u>	LENGTH OF STAY (in this place) <u>22 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hosp.</u>		STREET ADDRESS (If rural give location) <u>The Terraces, Mt Washington</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(Type or Print) <u>Nettie</u>	(First) <u>F.</u> (Middle) <u>Foster</u> (Last)	<u>4</u> <u>5</u> <u>1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S.</u>	8. DATE OF BIRTH: <u>5. 25. 1871</u>
9. AGE last birthday, IF UNDER 1 YEAR IF UNDER 24 HRS		<u>83</u> yrs Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Librarian retired</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>William Foster</u>		14. MOTHER'S MAIDEN NAME: <u>Marian Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE		(A) <u>Coronary Thrombosis with chronic myocarditis</u> <u>unknown</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Hypertensive cardiovascular disease</u> <u>unknown</u>	
		DUE TO <u>Pyelitis</u> <u>unknown</u>	
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3. 14</u> , 19 <u>55</u> , to <u>4</u> <u>5</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4</u> <u>4</u> , 19 <u>55</u> , and that death occurred at <u>5</u> <u>4</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Gertrude J. Fleischmann</u>		DATE SIGNED <u>4. 5. 55</u>	
ADDRESS <u>M. D. Spring Grove St. Hosp.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>Apr. 7-1955</u>		<u>Greenmount</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Baltimore</u>		<u>Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-6-55</u>		REGISTRAR'S SIGNATURE <u>Wm Cook Inc</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3416

Item 22, Film 180 4-13-55 at

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
X TOWN <u>Fort Howard, Maryland</u>		<u>449 Days</u>		STREET ADDRESS (If rural give location) <u>850 W. 34th Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
<u>WILLIAM T. FRANTOM</u>				<u>April 8 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>10/5/88</u>	
9. AGE last birthday <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Garden work</u>		11. BIRTHPLACE (State or foreign country): <u>Carroll Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Frantom</u>				14. MOTHER'S MAIDEN NAME: <u>Annie Bell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>216 10 9394</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>METASTATIC CARCINOMA WITH TRACHEO-ESOPHAGEAL FISTULA</u>						<u>Unknown</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>54</u>			
22. I hereby certify that <u>VA</u> attended the deceased from Jan. <u>14</u> , 19 <u>55</u> , to April <u>8</u> , 19 <u>55</u> and that death occurred at <u>12:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>George Lerner, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>4-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/14/55</u>		REGISTRAR'S SIGNATURE <u>A. D. Dedrick</u>		24. FUNERAL DIRECTOR: <u>William Cook-Blight Inc</u>		ADDRESS <u>6009 Harford, Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3355

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Baltimore</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Randall</u>		RURAL LENGTH OF STAY (in this place) <u>years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Randall</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3428 Solbus Pl. Rd.</u>				STREET ADDRESS (If rural give location) <u>3428 Solbus Pl. Rd.</u>			
3. NAME OF DECEASED:		(First) <u>Grover</u>		(Middle) <u>Cheverand</u>		(Last) <u>FRITZ</u>	
(Type or Print)						4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>13</u> (Year) <u>1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>Aug. 7-1885</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>tenant</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Alexander Fritz</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Hooper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No: <u>215-26-1148</u>		17. INFORMANT & ADDRESS: <u>W. C. Fritz, Randall, Md.</u>			
(If Yes, give war or dates of service)							

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death	
Immediate cause		(a) <u>Coronary Occlusion</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		(b) <u>Chronic Myocarditis</u>		<u>10 yrs.</u>	
		(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION: <u>W</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 4-23, 1955, to 4-13, 1955; that I last saw the deceased alive on 4-7, 1955, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

SIGNATURE <u>M. J. Davis M.D.</u>		ADDRESS <u>Dundalk 22. Md.</u>		DATE SIGNED <u>4/13/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>4/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>	
LOCATION (City, town, or county) <u>New Windsor, Md.</u>		DATE RECD BY LOCAL REGISTRAR <u>April 18-1955</u>		REGISTRAR'S SIGNATURE <u>William N. Kelly</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>New Windsor, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ROBERT A. S.

1955

10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

03391

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE _____ COUNTY _____	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN _____	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Gleason Rd</u>		STREET ADDRESS (If rural, give location) _____	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Meta Gaugler</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct. 10, 1868</u>
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Wurtemberg Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph Gaugler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Baumgartner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>442 Immediate cause (a) <u>Hypertensive cardiovascular disease</u></p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____</p>		<u>25 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 3, 1955, to April 10, 1955, that I last saw the deceased alive on April 3, 1955, and that death occurred at 5:25 P.m., from the causes and on the date stated above.

SIGNATURE <u>William A. Priestley</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Towson</u>	DATE SIGNED
23. BURIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-13-55</u>	NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>	LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NEAR TOWSON</u>
DATE REC'D BY LOCAL REG. <u>4-12-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Charles S. Guler</u>	ADDRESS <u>901 S. CONKLIN ST. BALTO., MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3362
CERTIFICATE OF DEATH

03392

Reg. Dist. No. 42

1. PLACE OF DEATH: COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arbutus HOSPITAL OR INSTITUTION OR STREET ADDRESS 4111 Wilkens Ave				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arbutus STREET ADDRESS 4111 Wilkens Ave			
3. NAME OF DECEASED: (Type or Print) John J. Glick (First) (Middle) (Last)				4. DATE OF DEATH: Apr. 21, 1955 (Month) (Day) (Year)			
5. SEX: male		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH: Oct. 19, 1883	
9. AGE last birthday: 71 yrs.		10. IF UNDER 1 YEAR: Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? US	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Owner Rest.				10b. KIND OF BUSINESS OR INDUSTRY: Rest. Owner			
11. BIRTHPLACE (State or foreign country): Baltimore				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME: John Glick				14. MOTHER'S MAIDEN NAME: Barbara Spahn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY No.: 212-30-5509			
17. INFORMANT & ADDRESS: Anna G. Glick, 4111 Wilkens Ave							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause DUE TO Sudden & Complete Coronary Occlusion						Immediate	
(b) Antecedent cause(s) DUE TO Arteriosclerotic C.V. Disease						?	
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 1947 , to April 21, 1955 , that I last saw the deceased alive on April 21, 1955 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above.							
SIGNATURE John T. Coalahan, M.D.				ADDRESS 4201 Wilkens Ave		DATE SIGNED 4/22/55	
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF 4-25-55		NAME OF CEMETERY OR CREMATORY New Cathedral		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REG. Apr 23 55		REGISTRAR'S SIGNATURE Geo. Tieffer		24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave	

BUREAU V. B.

PR 25 1955

201 V. B.

3418

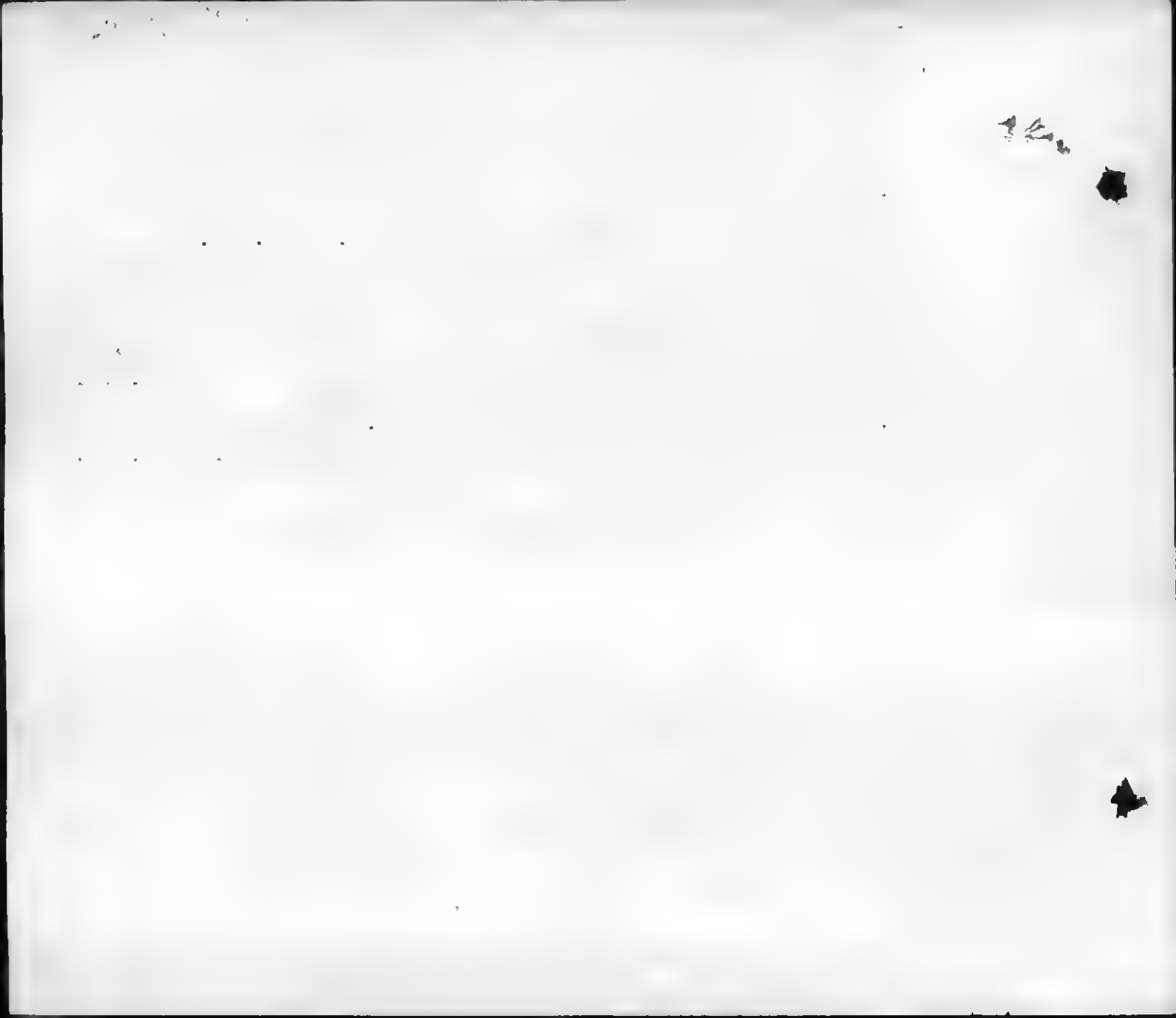
CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> City	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Wilson</u> LENGTH OF STAY (in this place) <u>112 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore - 11</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>841 W. 37th. St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Milton Edwin-- Gossom</u>		<u>4 7 19 55</u>	
5. SEX: <u>Male</u> 6. COLOR OR RACE: <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>		8. DATE OF BIRTH: <u>5/22/1891</u> 9. AGE last birthday <u>63</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Embalmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas E. Gossom</u>		14. MOTHER'S MAIDEN NAME: <u>Marion A. Garner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-09-5012</u>	
17. INFORMANT & ADDRESS: <u>841 W. 37th. St. Milton Gossom, Baltimore 11, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Carcinoma of Lung</u>			<u>3 years</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST DUE TO (B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11/16, 1954</u> to <u>4/7, 1955</u> that I last saw the deceased alive on <u>4/7, 1955</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William Newcomer</u> WM. NEWCOMER, M.D. Mt. Wilson, Maryland		DATE SIGNED <u>4/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 12, 55</u>	
NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>	
24. FUNERAL DIRECTOR <u>Ellsworth Armistead</u>		ADDRESS <u>4600 Liberty High</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3419

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <i>Baltimore</i>	MARYLAND—		STATE <i>Maryland</i>	COUNTY <i>Prince Georges</i>	
CITY (If outside corporate limits, write RURAL OR and nearest town) <i>Catonsville</i>	LENGTH OF STAY (in this place) <i>2 years</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>BERWYN, Md.</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove State Hosp.</i>			STREET ADDRESS (If rural give location) <i>9412 Baltimore Ave.</i>		
3. NAME OF DECEASED (Type or Print) <i>SAMUEL JACKSON GRADY</i>			4. DATE (Month) (Day) (Year) OF DEATH <i>APRIL 11 1955</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>Sep.</i>	8. DATE OF BIRTH: <i>7 1882</i>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <i>Govt. emp.</i>			9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. <i>71</i> yrs. Months Days Hours Min.		
10B. KIND OF BUSINESS OR INDUSTRY: <i>—</i>			11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		
13. FATHER'S NAME: <i>Jas. P. Grady</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>?</i>			14. MOTHER'S MAIDEN NAME: <i>Mary Jane</i>		
16. SOCIAL SECURITY NO. <i>?</i>			17. INFORMANT & ADDRESS: <i>Mrs. Lorraine Barrett (above address)</i>		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
IMMEDIATE CAUSE <i>154X</i>					
ANTECEDENT CAUSE (S):					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.					
(A) <i>Respiratory failure associated with intra-cerebral hemorrhage possibly due to</i>					
(B) <i>Metastatic malignant tumor of brain due to</i>					
(C) <i>Primary adenocarcinoma of rectum & colon involvement of prostate, lungs, and probably cerebellum.</i>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19A. DATE OF OPERATION: <i>Sept. 1953</i>					
19B. MAJOR FINDINGS OF OPERATION: <i>Adenocarcinoma of rectum; bowel resection and cholecystomy</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>M</i>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4/24</i> , 19 <i>53</i> , to <i>4/11</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4/11</i> , 19 <i>55</i> , and that death occurred at <i>6:20 p. M.</i> from the causes and on the date stated above.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4/15/55</i>		NAME OF CEMETERY OR CREMATORY <i>St. Lincoln</i>	
DATE REC'D BY LOCAL REGISTRAR <i>April 14 1955</i>		REGISTRAR'S SIGNATURE <i>T.E. Harry</i>		24. FUNERAL DIRECTOR <i>Joseph Sore Nystrom, Md.</i>	
				ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

26.

3420

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03395 Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN BALTO. 12	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN Baltimore 12	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS 712 WALKER AVE.		STREET ADDRESS (If rural, give location) 712 Walker Avenue	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) MARY	(Middle) ELIZABETH	(Last) GUNN	(Month) 4 (Day) 11 (Year) 19 55
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED DEC. 12, 1864	8. DATE OF BIRTH: 18 4 9. AGE last birthday: 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME	11. BIRTHPLACE (State or foreign country): MARYLAND
13. FATHER'S NAME: JOHN AGOST AXER		14. MOTHER'S MAIDEN NAME: SUSANNA HECK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO		16. SOCIAL SECURITY No.: NONE	
17. INFORMANT & ADDRESS: MRS ROSALIE BERRY BALTO. 12, MD.		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause (a) Confluent bronchopneumonia, right upper, and middle lobes Antecedent cause(s) (b) Organizing empyema, right thorax Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? partial
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE W. C. V. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/12/55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	DATE THEREOF APR. 14, 1955	NAME OF CEMETERY OR CREMATORY ROCK SPRING CEMETERY
DATE REC'D BY LOCAL REG April 14, 1955	REGISTRAR'S SIGNATURE Mabel C. Gray	LOCATION (City, town, or county) (State) FOREST HILL, HARFORD CO., MD.
24. FUNERAL DIRECTOR		ADDRESS John Burns' Sons, Towson, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1

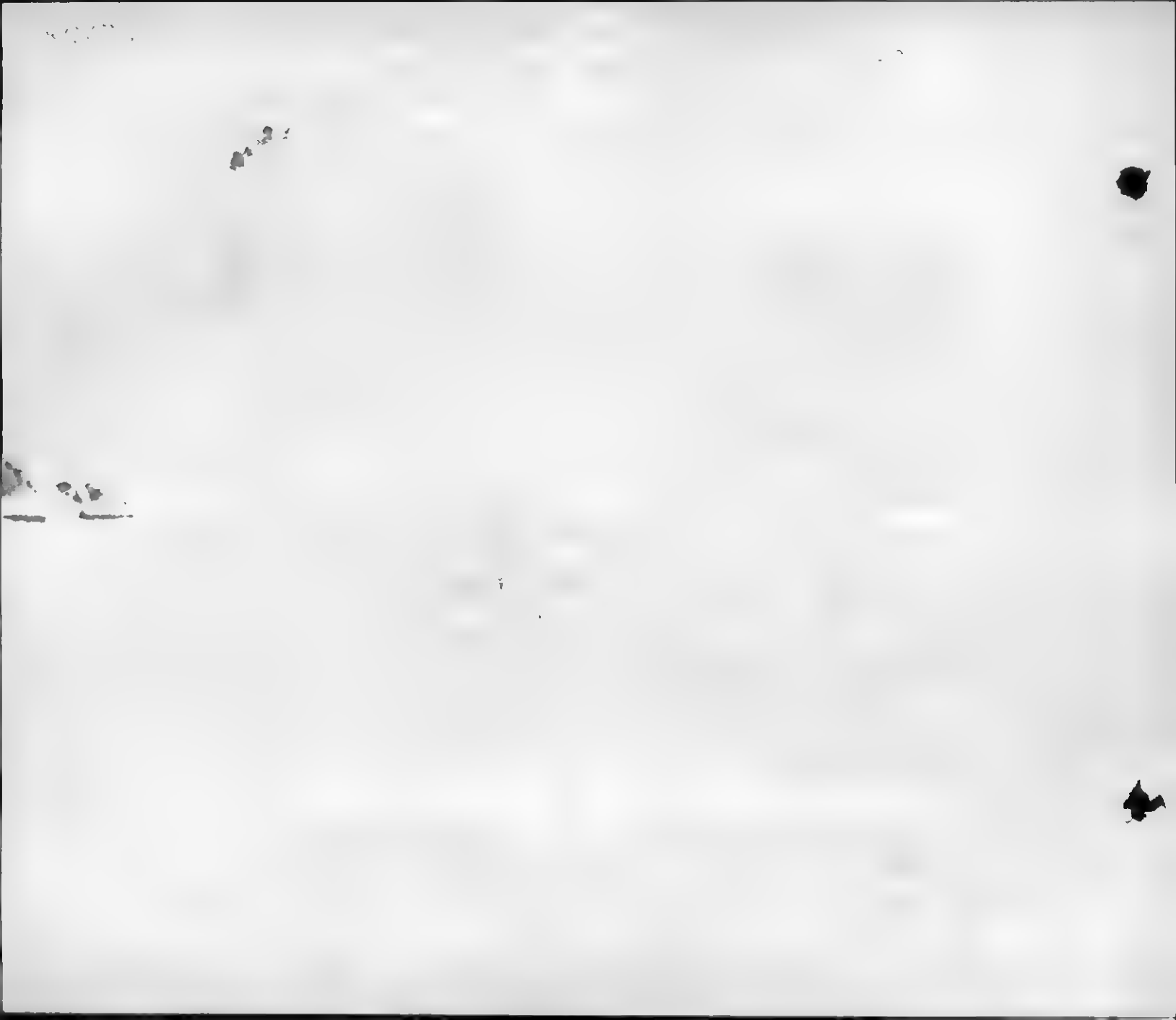
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **03396**

3421 CERTIFICATE OF DEATH

Reg. Dist. No. **38**

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Stoneleigh</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>605 Kingston Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Stoneleigh</u> STREET ADDRESS (If rural give location) <u>605 Kingston Road</u>	
3. NAME OF DECEASED: (First) <u>Robert</u> (Middle) <u>Adams</u> (Last) <u>Harp</u> (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH <u>April 17, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 14, 1942</u>
9. AGE last birthday <u>12</u> yrs Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Student</u>	
10A. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
13. FATHER'S NAME: <u>Maynard E. Harp</u>		14. MOTHER'S MAIDEN NAME: <u>Retta Elizabeth Potter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Maynard E. Harp 605 Kingston Road</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 237X IMMEDIATE CAUSE <u>Hydrocephalus</u> ANTECEDENT CAUSE (S): <u>Brain Tumor</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST <u>Convulsions</u>		INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>March 10, 1952</u> to <u>April 17, 1955</u>, that I last saw the deceased alive on <u>April 17, 1955</u>, and that death occurred at <u>1:30 AM</u>, from the causes, and on the date stated above.	
SIGNATURE <u>Laurence C. Tash</u>		ADDRESS <u>6805 York Rd Baltimore Md</u>	
DATE SIGNED <u>4/18/55</u>		DATE REC'D BY LOCAL REGISTRAR <u>4-18-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Apr. 18, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm J. Tishener</u>		ADDRESS <u>Home 70 Pa Balto</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3422 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03397			
CERTIFICATE OF DEATH			
Reg. Dist. No. 30			
Item 11, Film 180 4-19-55 et			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Catonsville</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore (17)</u>	
HOSPITAL, OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hosp.</u>		STREET ADDRESS (If rural give location) <u>2311 Collier Ave. No. 4</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Shinnie C. Helfrich</u>		OF DEATH: <u>4 9 19 55</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11. 8. 1880</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		9. AGE last birthday: <u>74</u> yrs	
10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>	
13. FATHER'S NAME: <u>Nicholas</u>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Fillinger</u>	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>Hospital Bureau</u>	
16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		hours	
570.3 IMMEDIATE CAUSE (A) <u>Volvulus of sigmoid colon</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3/29</u> , 19 <u>55</u> , to <u>4/9</u> , 19 <u>55</u> that I last saw the deceased alive on <u>4/9</u> , 19 <u>55</u> , and that death occurred at <u>11:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachter</u>		DATE SIGNED <u>4/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-13-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mellinger Mennonite Cem.</u>		LOCATION (City, town, or county) (State) <u>Lancaster, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/10/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Jaeger Funeral Home, 317 E. Orange St. Lancaster, Pa.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3423

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....

8. AGE: Years..... Months..... Days.....
 (If less than one day)..... hrs. min.

9. Birthplace.....
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. BURIAL Date thereof.....

(Burial, cremation, or removal. Which?).....

Cemetery or crematory.....

Local on.....

18. Funeral director.....

Address.....

19. 4-26-55 Date rec'd by registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

and that I last saw him/her alive on.....

Immediate cause of death.....

Other conditions.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other.....

Address.....

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15 9-45 15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03399

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

3424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore County</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1812 Hanford Road</u>		STREET ADDRESS (If rural, give location) <u>1812 Hanford Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Edward</u> (Middle) <u>Adam</u> (Last) <u>Himmelheber</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 6, 1890</u>
9. AGE last birthday <u>75</u> yrs.		10. If under 1 year: Months <u>8</u> Days <u>8</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Himmelheber</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Steinman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Wilhelmina Himmelheber - 1812 Hanford Rd</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>IX</u> Immediate cause (a) <u>Cerebral hemorrhage</u> Antecedent cause(s) (b) <u>Arteriosclerosis, embol</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 1/2</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/26</u> , 19 <u>54</u> , to <u>8 April</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/11</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u> (Degree or title)		ADDRESS <u>115 W. Milton Ave</u> DATE SIGNED <u>8 April 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 11, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REG. <u>April 9, 1955</u>	REGISTRAR'S SIGNATURE <u>R.W.</u>	24. FUNERAL DIRECTOR <u>John C. Miller Inc. 2431 E. Oliver St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03400

Reg. Dist. No. 30

3425

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westchester Ave.				STREET ADDRESS Westchester Ave.			
3. NAME OF DECEASED (Type or Print) BEULAH ETHEL HIPSLEY		(First) (Middle) (Last)		4. DATE OF DEATH 4-4-55		(Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 10-18-1884	9. AGE last birthday 70 yrs.	If under 1 year Months Days Hours Min.		If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Pella, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles King				14. MOTHER'S MAIDEN NAME Josephine Atkinson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT AND ADDRESS Richard J. Hipsley, Ellicott City, Md			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

412.1
Immediate cause

(a) **Cerebral Arteriosclerosis**

INTERVAL BETWEEN
ONSET AND DEATH

1 year

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) **Anteroinfarctive Cardio-Vascular Disease**

3 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

None

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICID HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 2 , 19 51 , to April 4 , 19 55 , that I last saw the deceased alive on April 2 , 19 55 , and that death occurred at 6 A. m., from the causes and on the date stated above.					
SIGNATURE William F. Garrison		(Degree or title) M.D.		ADDRESS Ellicott City, Md	
DATE SIGNED 4/4/55					
23. BURIAL CREMATION REMOVAL (Specify) Burial		DATE THEREOF 4-7-1955		NAME OF CEMETERY OR CREMATORY Loudon Park	
LOCATION (City, town, or county) Baltimore, Md		(State)			
DATE REC'D BY LOCAL REG. 4/6/55		REGISTRAR'S SIGNATURE V. E. Harry		24. FUNERAL DIRECTOR F. C. Higinbotham, Ellicott City, Md	
ADDRESS					

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

LEONARD V. S.

APR

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03401

3426

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
TOWN <u>Pikesville</u>		TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4150 Fallstaff Road</u>		STREET ADDRESS (Rural, give location) <u>4150 Fallstaff Road</u>	
3. NAME OF DECEASED (First) <u>Edgar</u> (Last) <u>Holmes</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>10</u> (Year) <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 4, 1883</u>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Samuel J. Holmes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Black</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>312-10-2082</u>	
17. INFORMANT AND ADDRESS <u>Mary B. Holmes, 4150 Fallstaff Rd.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Thrombosis</u>		
Antecedent cause(s) (b) <u>Coronary artery disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary artery disease</u>		<u>Unknown</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 30, 1954, to Apr. 9, 1955, that I last saw the deceased alive on Apr. 9, 1955, and that death occurred at 2:00 p.m., from the causes and on the date stated above.

SIGNATURE <u>B. B. Ensor MD</u>	DATE <u>April 13/55</u>	ADDRESS <u>7201 York Rd. Balto. Co. Md.</u>
23. BURIAL, CREMATION REMOVAL (Specify)	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Landon Park</u>	<u>Balto, Md.</u>
DATE REC'D BY LOCAL REG. <u>4/12/55</u>	REGISTRAR'S SIGNATURE <u>W. L. Leach</u>	24. FUNERAL DIRECTOR <u>Loring Byers, 5005 Park Heights</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03402

3427

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>ALTI MORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3626 FOREST HILL ROAD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u> STREET ADDRESS (If rural, give location) <u>3626 FOREST HILL ROAD</u>	
3. NAME OF DECEASED (Type or Print) <u>LOUISE</u>	(First) <u>M.</u>	(Last) <u>HOLMES</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 13 1955</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>March, 27th 1891</u>
9. AGE last birthday <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK - S ITPIC DEPT</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>DEPT STORE</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD STAFF</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-10-3048</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Edwin H. Reich, 3626 Forest Hill Road</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>416X</u> Immediate cause (a).... <u>Antecedent cause(s)</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Cardiac De compensation</u> <u>Rheumatic heart disease</u> <u>Arthritis deformans</u>		<u>Unknown</u> <u>Many yrs</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-10-55, 1955, to 4-13, 1955, that I last saw the deceased alive on 4-11, 1955, and that death occurred at 4:30 A. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

E. B. Enzor M.D.7201 York Rd Baltimore 12 Md

23. BURIAL, CREMATION, REINSTATEMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>April, 15th 1955</u>	<u>Loudon Park Cemetery</u>	<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS	
<u>4-15-55</u>	<u>Edw. H. Reich</u>	<u>Edw. H. Reich</u>	<u>4510 Liberty Heights Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



3428

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) MARYLAND

55 TOWN Rural: Towson

HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore 12, Md. 34014

STREET ADDRESS (If rural give location)

3004 White Ave.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

ZELMA

L.

HUBERT

(Type or Print)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

April 30,

19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Female

white

widowed

March 13, 1886

69 yrs.

Months

Days

Hours

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Housewife

Harrisonburg, Va.

U.S.A.

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

ALBERT CLARK

FLORENCE Leavelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Hospital Records - Eudowood Sanatorium

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Pulmonary Tuberculosis

Interval Between Onset And Death

28 mo.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 24, 1953, to April 30, 1955, that I last saw the deceased

alive on April 24, 1955, and that death occurred at 8:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Milton B. Kress M.D.

Eudowood Sanatorium - Towson 4, Md.

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

LOCATION (City, town, or county)

ADDRESS

5-2-55

A. W. Johnson

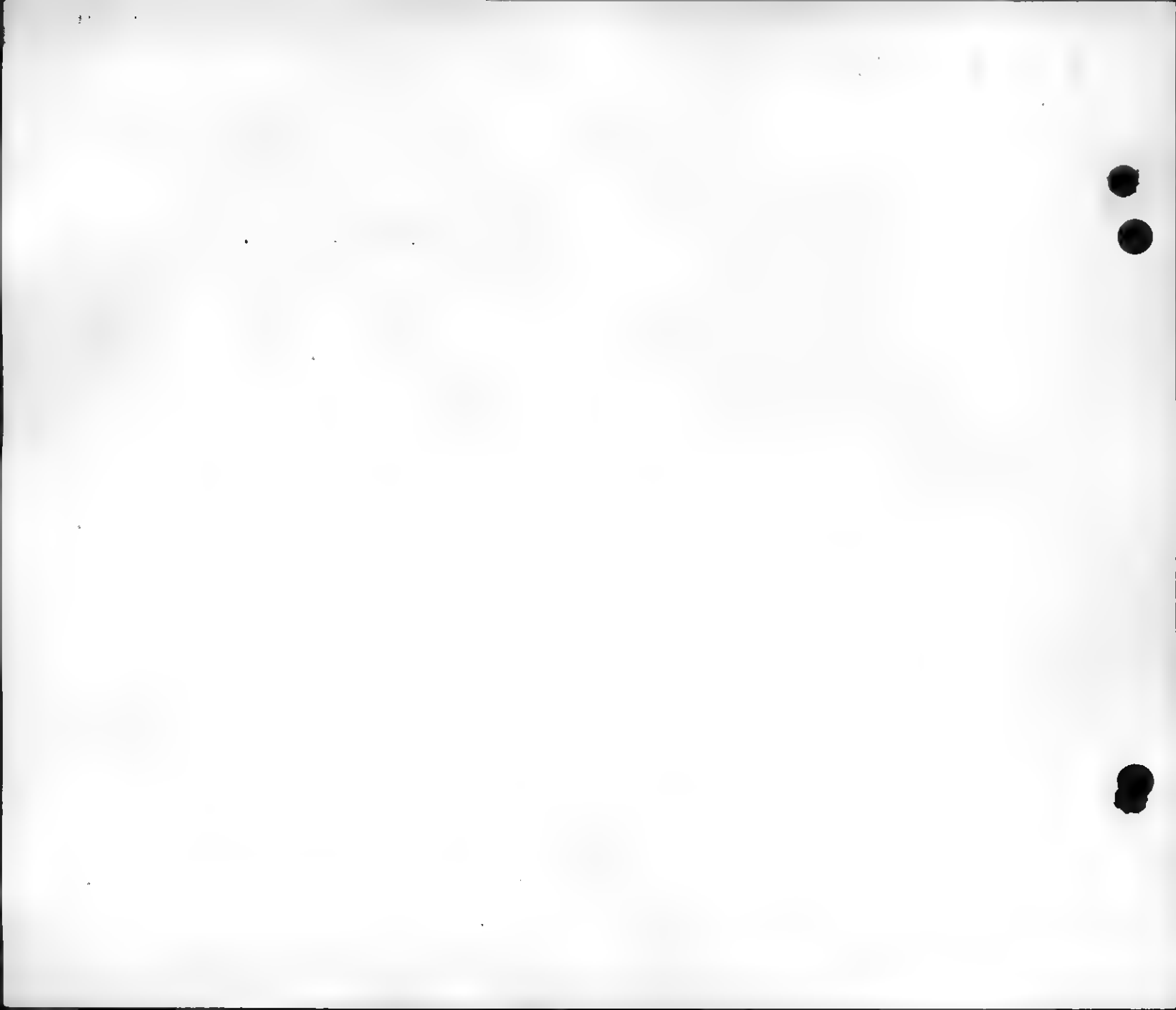
Wm. J. Tichenor Sons

Baltimore 17 Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3429

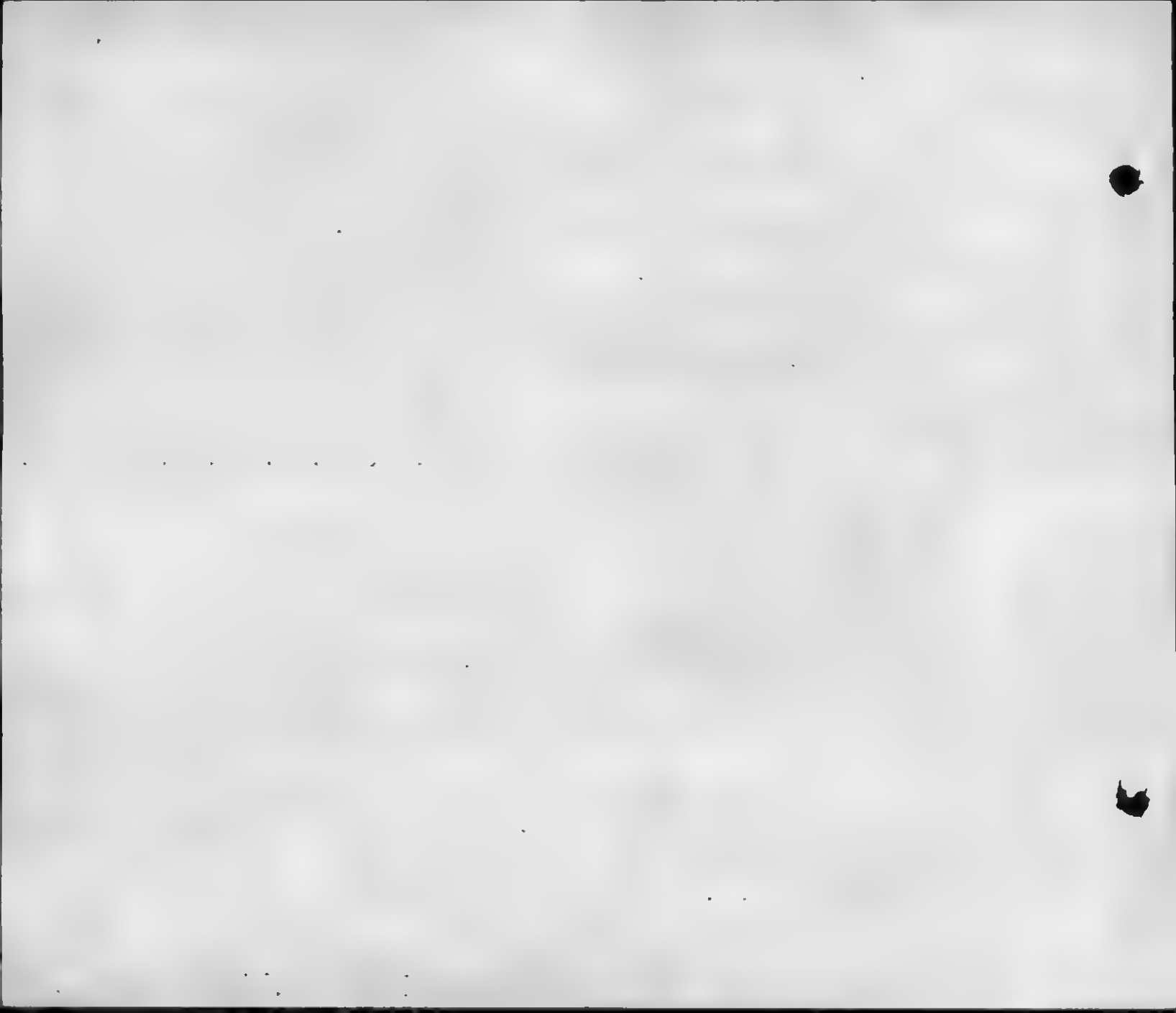
CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Fort Howard</u>	<u>38 Days</u>	OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>2404 E. Oliver Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JOHN W. HUEBENTHAL</u>		<u>April 3, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>4/14/99</u>
9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Police Force</u>	
11. BIRTHPLACE (State or foreign country): <u>San Francisco, California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Peter Huebenthal</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Schultz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give year or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-30-1920</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>MYOSARCOMA, RIGHT LUNG AND THORAX</u>			<u>UNKNOWN</u>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHOPNEUMONIA, ARTERIOSCLEROTIC HEART DISEASE</u>			
19A. DATE OF OPERATION: <u>3/24/55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>THORACOTOMY, RIGHT WITH EXCISION OF TISSUE FOR BIOPSY</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>Feb. 24, 1955</u> , to <u>April 3, 1955</u> , that I last saw the deceased <u>about 5:50 AM</u> , and that death occurred <u>at 5:50 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Abraham Polachek, M.D.</u>		ADDRESS <u>M. D. FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>4/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-6-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-4-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>John C. Miller Inc. Funeral Home</u>		ADDRESS <u>2431 E. Oliver St., Baltimore 13, Md.</u>	



3430

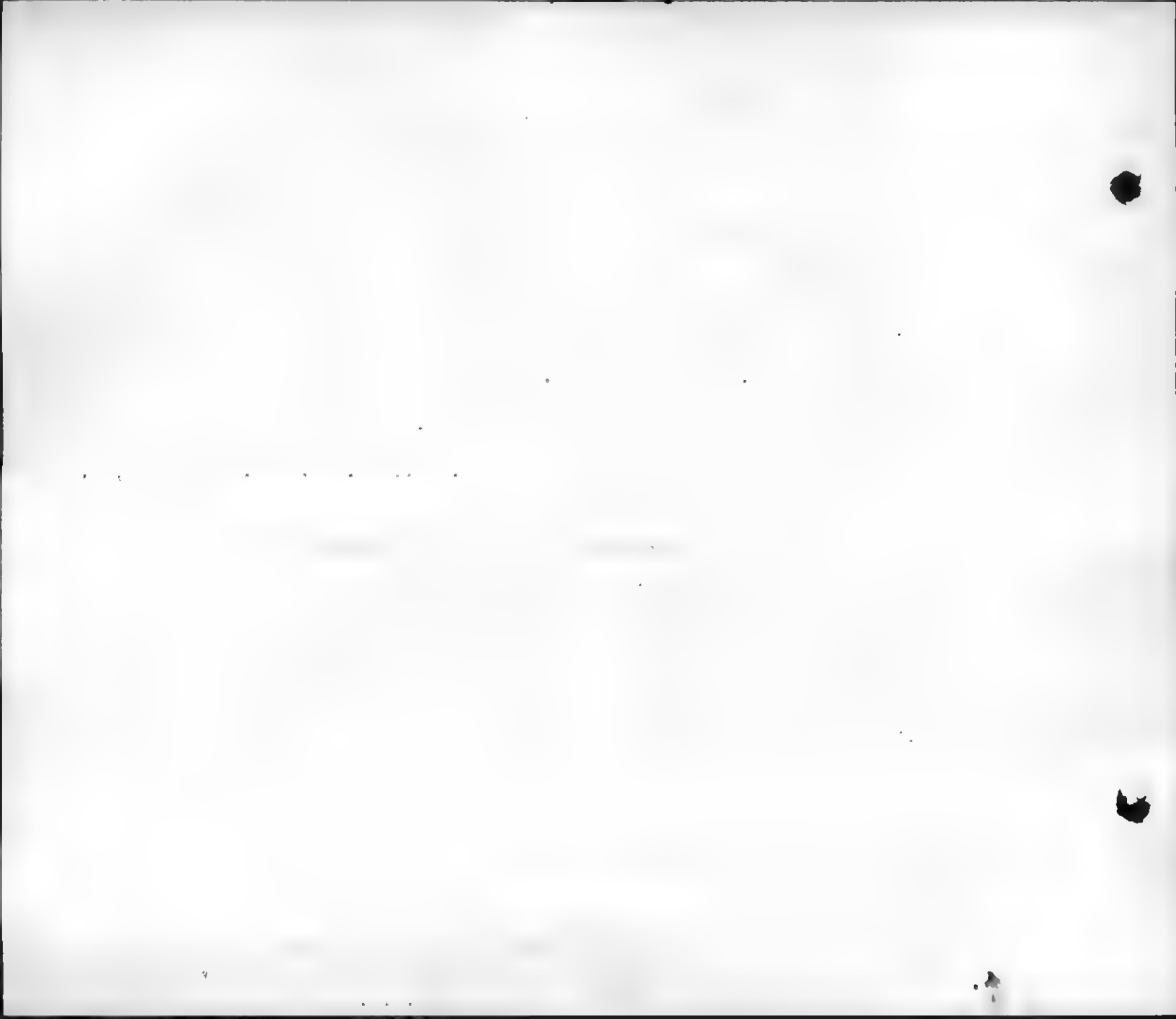
CERTIFICATE OF DEATH

Reg. Dist. No. 16-1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD	LENGTH OF STAY (In this place) 12 DAYS	CITY (If outside corporate limits, write RURAL and give nearest town) OR HYATTSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 4011 BUCHANAN STREET	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) DEWITT	(Middle) (NMI)	(Last) HUMPHREY	DEATH: APRIL 27 1955
5. SEX. MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: 2/21/16
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HEAVY EQUIP. OP. CONSTRUCTION CO.		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: 39 yrs. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): AUSTEL, GEORGIA		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME: ARTHUR HUMPHREY		14. MOTHER'S MAIDEN NAME: MARY E. ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): YES (If Yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 577 10 0764	
17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 401.1		3 WEEKS	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		7 YEARS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APRIL 15 1955 , to APRIL 27, 1955 and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT		DATE SIGNED 4/28/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL		NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY FORT MEYERS, VIRGINIA	
DATE REC'D BY LOCAL REGISTRAR APR. 29, 1955		24. FUNERAL DIRECTOR WILLIAM COOK-BLIGHT INC	
SHIPPED TO: WW CHAMBERS CO. 1400 CHAPIN ST. N.W. WASH. D.C.		ADDRESS 6009 HARFORD RD BALTO. MD	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03406

3431

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3 /

1. PLACE OF DEATH- COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) WOODLAWN HOSPITAL OR INSTITUTION OR STREET ADDRESS 2264 St. Lukes Lane		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY Baltimore CITY (If outside corporate limits, write RURAL and give nearest town) WOODLAWN STREET ADDRESS (If rural, give location) 2264 St. Lukes Lane	
3. NAME OF DECEASED (Type or Print) EMMA (First) L (Middle) IMWOLD (Last)		4. DATE OF DEATH April, 14th 1955 (Month) (Day) (Year)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 29, 1871
9. AGE last birthday 83 yrs.		10. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE GETTINGS		14. MOTHER'S MAIDEN NAME DORTHY ANN YEADAKER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Mrs. Thos. W. McConville 2264 St. Lukes Lane		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 3X Immediate cause (a) Carcinoma of colon Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH 4 years	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE PLACE (Home, farm, factory, street, OF HOMICIDE (CITY OR TOWN) (COUNTY) (STATE)			
TIME (Month) (Day) (Year) (Hour) 4/14/55 INJURY OCCURRED While at Work HOW DID INJURY OCCUR? At work			
22. I hereby certify that I attended the deceased from 12/25, 1945 to 4/14, 1955 , that I last saw the deceased alive on 4/14, 1955 , and that death occurred at 3.05 P.m. , from the causes and on the date stated above.			
SIGNATURE Robert A. Reiter, M.D. (Degree or title)		ADDRESS 3418 Windsor Ave. DATE SIGNED 4/10/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE THEREOF April 18, 1955 NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery LOCATION (City, town, or county) Balto Co Maryland (State)			
DATE REC'D BY LOCAL REG. 4-18-55 REGISTRAR'S SIGNATURE W. W. Adams FUNERAL DIRECTOR W. W. Adams ADDRESS 4510 Liberty Heights Ave.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3432

CERTIFICATE OF DEATH

Reg. Dist. No.

03407

50

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>Catonsville</u> OR <u>and give nearest town</u> TOWN <u>Catonsville</u> Length of stay (In this place) <u>1yr 7mo 29days</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baldwin</u> OR <u>and give nearest town</u> TOWN <u>Baldwin</u> STREET ADDRESS (If rural give location) <u>1</u>	
14 HOSPITAL OR INSTITUTION OR ADDRESS <u>Spring Grove State Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Elsie Isennock</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 26, 1955</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH <u>6-23-1881</u> 9. AGE last birthday, IF UNDER 1 YEAR IF UNDER 24 YRS <u>73 yrs</u> Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Isennock</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Walton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>			
ANTECEDENT CAUSE (S) DUE TO		Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Generalized arteriosclerosis</u>		Years	
260X (C) <u>Diabetes Mellitus</u>		Years	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OR INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8-23-</u> , <u>1953</u> , to <u>4-26-</u> , <u>1955</u> , that I last saw the deceased alive on <u>4-26-</u> , <u>1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u> ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>4-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> DATE THEREOF <u>4/30/55</u> NAME OF CEMETERY OR CREMATORY <u>PROTESTANT CHURCH</u> LOCATION (City or town, or county) (State) <u>Catonsville 28 Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>4-29/55</u> REGISTRAR'S SIGNATURE <u>H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>E. H. H. H.</u> ADDRESS <u>Fork Md</u>	



3433

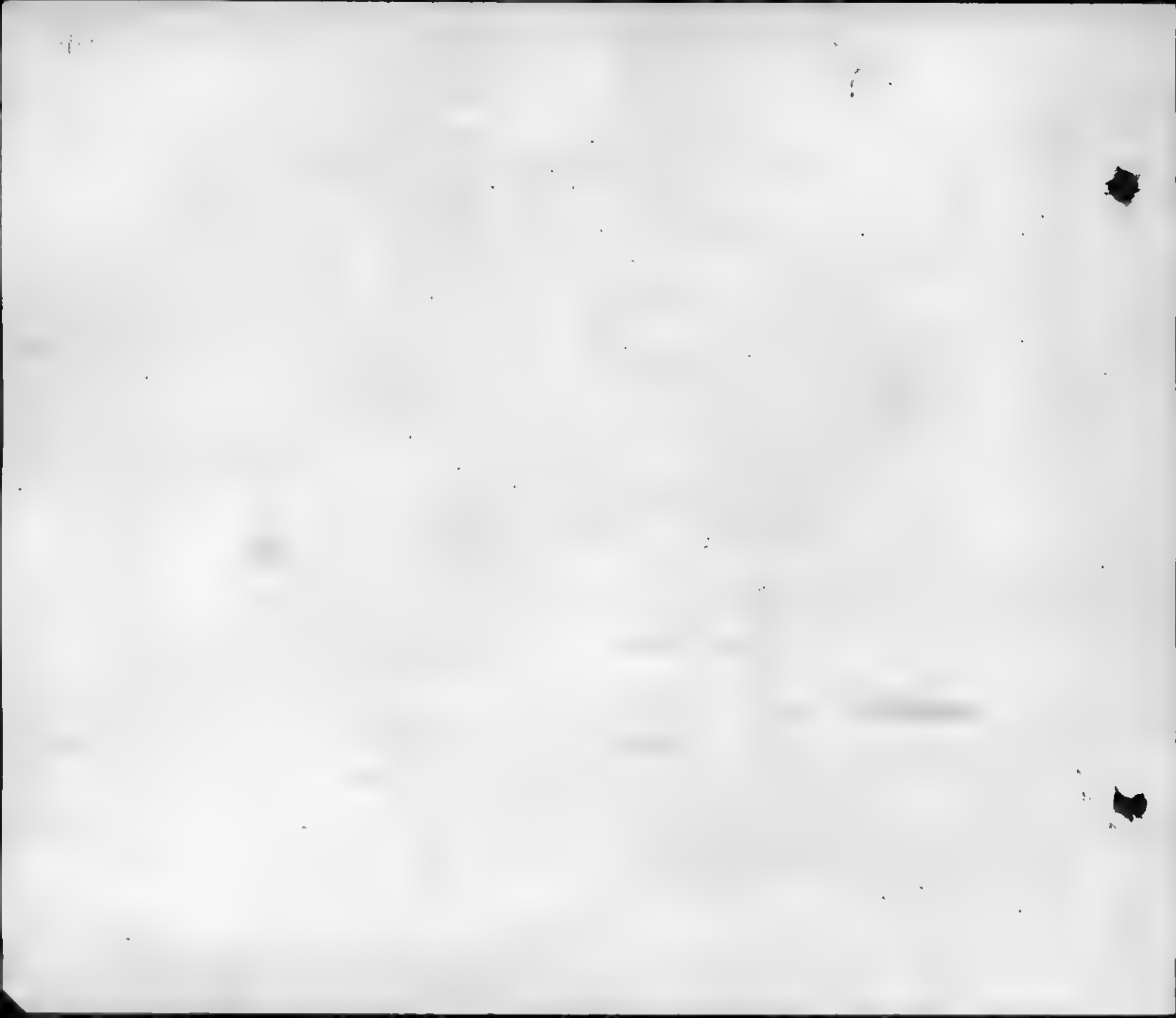
CERTIFICATE OF DEATH

Reg. Dist. No. *KX*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN FORT HOWARD)	LENGTH OF STAY (In this place) 21 hrs. 50 min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS (If rural give location) 1115 MADISON AVENUE		
3. NAME OF DECEASED: (First) EARLIE (Middle) L. (Last) JAMES		4. DATE (Month) (Day) (Year) OF DEATH April 23, 19 55	
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: 6-19-95
9. AGE last birthday 59 yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor		10B. KIND OF BUSINESS OR INDUSTRY: Pipe Mill	
11. BIRTHPLACE (State or foreign country): Craddockville, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Henry James		14. MOTHER'S MAIDEN NAME: Martha Sample	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 115-07-3915	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
4211 IMMEDIATE CAUSE CALCIFIC DISEASE OF AORTIC VALVE WITH STENOSIS AND INSUFFICIENCY		10 years	
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 23 1955 , to April 28 1955 , that I last saw the deceased at VAH , and that death occurred at 10:50M , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS VAH, Fort Howard, Md. DATE SIGNED 4/24/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/24/1955	
NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 4-25-55		REGISTRAR'S SIGNATURE AW Hedrick	
24. FUNERAL DIRECTOR Arlington S. Phillips Funeral Home		ADDRESS 1808 N. Monroe St. Baltimore, Maryland	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3434

CERTIFICATE OF DEATH

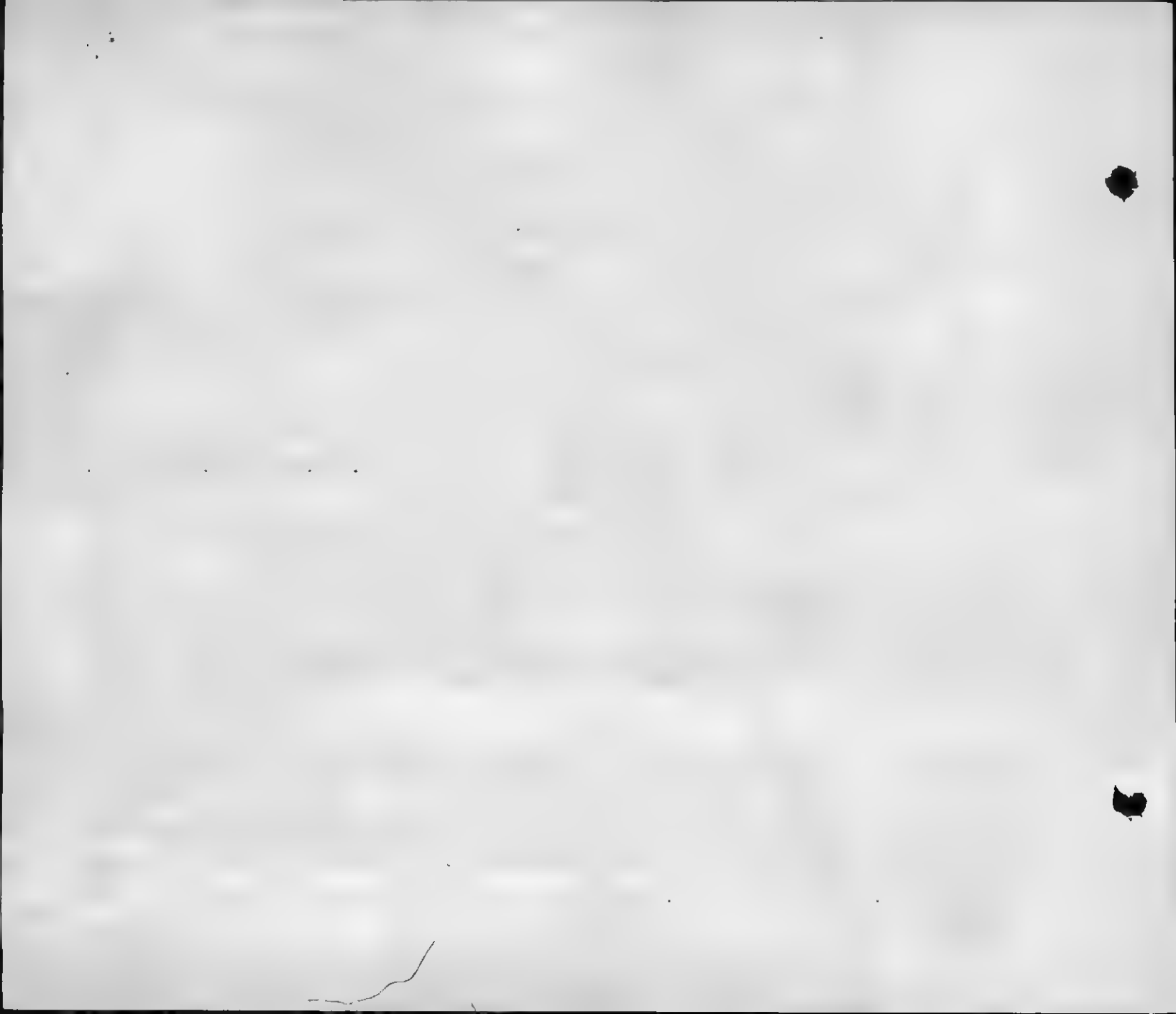
Reg. Dist. No.

X X

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD</u> TOWN <u>FORT HOWARD</u> LENGTH OF STAY <u>14</u> DAYS (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSP.</u>				STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) _____ OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>2004 HOMEWOOD AVENUE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ISAAC</u> (NMI) <u>JOHNSON</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 12 1955</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>COLORED</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>MARRIED</u>		8. DATE OF BIRTH: <u>10/20/89</u>	
9. AGE last birthday: <u>65</u> yrs.		10. MONTHS <u>12</u> DAYS <u>15</u> HOURS <u>55</u> MIN.		9. AGE last birthday: IF UNDER 1 YEAR		IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>JANITOR</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Y M C A</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME: <u>THOMAS JOHNSON</u>				14. MOTHER'S MAIDEN NAME: <u>OLIVIA SPENCE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW I</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S) <u>CEREBRAL HEMORRHAGE, LEFT MIDDLE CEREBRAL ARTERY</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE LAST STATING UNDERLYING CAUSE LAST <u>DUE TO: ARTERIOSCLEROSIS, GENERALIZED</u>							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MAR. 29, 1955</u> to <u>APRIL 12 1955</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				DATE SIGNED <u>APRIL 13 1955</u>			
FRANCIS G. DICKEY, M.D., Chief, Medical Service				VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>6-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-15-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>ISAIAH BROWN & SON, 108 W. MONTGOMERY ST. BALTIMORE, MD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2425
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03410

Reg. Dist.

No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:									
COUNTY <u>Baltimore</u> MARYLAND	STATE <u>Md</u> COUNTY <u>Baltimore</u>										
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Edgemere</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Edgemere</u>									
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>26 Cottage Ave</u>		STREET ADDRESS (If rural, give location) <u>26 Cottage Ave</u>									
3. NAME OF DECEASED:		4. DATE OF DEATH									
(Type or Print) (First) (Middle) (Last) <u>Arnold</u> <u>Jones</u>		(Month) (Day) (Year) <u>4-1-1955</u>									
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>9-27-51</u>								
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: <u>3</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>Months</td><td>Days</td><td>Hours</td><td>Min.</td></tr><tr><td></td><td></td><td></td><td></td></tr></table>	Months	Days	Hours	Min.				
Months	Days	Hours	Min.								
11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME: <u>Joseph R. Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Gertrude Camer Jones</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Gertrude C. Jones 256 Exeter St</u>									
18. MEDICAL CERTIFICATION											
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH								
Immediate cause (a) ... <u>4th Burns over entire body</u> DUE TO											
Antecedent cause(s) (b) ... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)											
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>No.</u>											
19a. DATE OF OPERATION: <u>No</u>		19b. MAJOR FINDING OF OPERATION: <u>No.</u>									
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>	21c. (City or town) <u>Baltimore</u> (County) <u>Md.</u> (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-1-55 10 P.M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Car into burning house</u>									
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE <u>Dr. J. S. Davis M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/1/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>									
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>	DATE THEREOF <u>4/2/55</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	LOCATION (City, town, or county) (State) <u>Balto., Md.</u>								
DATE REC'D BY LOCAL <u>April 4-55</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Harbor</u>	24. FUNERAL DIRECTOR <u>Charles K. Law 808 Madison Ave</u>									



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3553

034-11
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lansdowne</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Lansdowne</u>	51
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>224 Hazel ave</u>		STREET ADDRESS (If rural, give location) <u>224 Hazel ave</u>	
3. NAME OF DECEASED: (First) <u>Mordecai</u> (Middle) <u>Levi</u> (Last) <u>Kastner</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>13</u> (Year) <u>1935</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>July 3 1889</u>
9. AGE last birthday: <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, when it retired): <u>Retired collector</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Clothing</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Nathan L. Kastner</u>		14. MOTHER'S MAIDEN NAME: <u>Levi</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>215 07 0636</u>	
17. INFORMANT & ADDRESS: <u>Levi A. Kastner 4901 Sheffield St Apt 2</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <u>Acute cardiac failure</u>	DUE TO	
Antecedent cause(s) (b) <u>Bronchial asthma</u>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Cardiovascular disease.</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Geo M. Kieffer</u> 1010 Reed St		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED <u>April 21 1935</u>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>4-27-35</u>	NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship Cem</u>
LOCATION (City, town, or county) <u>Balto md</u>	(State)	
DATE REC'D BY LOCAL REG. <u>4/26/35</u>	REGISTRAR'S SIGNATURE <u>W. J. Cook</u>	24. FUNERAL DIRECTOR <u>Wm. Cook Inc. 1217 St Paul St</u>
		ADDRESS

25 Dec

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03412

3436

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>521</u> <u>Ca Lonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove St. Hospital</u>				STREET ADDRESS (If rural give location) <u>1720 Harden Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Rose</u> <u>Kaufman</u>				OF DEATH: <u>4</u> <u>5</u> <u>1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>2-7-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Abraham</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Kirshenbaum</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>						<u>5 days</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1</u> , 1954, to <u>4/5</u> , 1955, that I last saw the deceased alive on <u>4/5</u> , 1955, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wachler</u>		M.D. <u>Spring Grove St. Hospital</u>		DATE SIGNED <u>4/5/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-6-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/5/55</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		24. FUNERAL DIRECTOR <u>Jack Lewis</u>		ADDRESS <u>2100 Eutaw Pl</u>	

11

12

13

14

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3437

CERTIFICATE OF DEATH

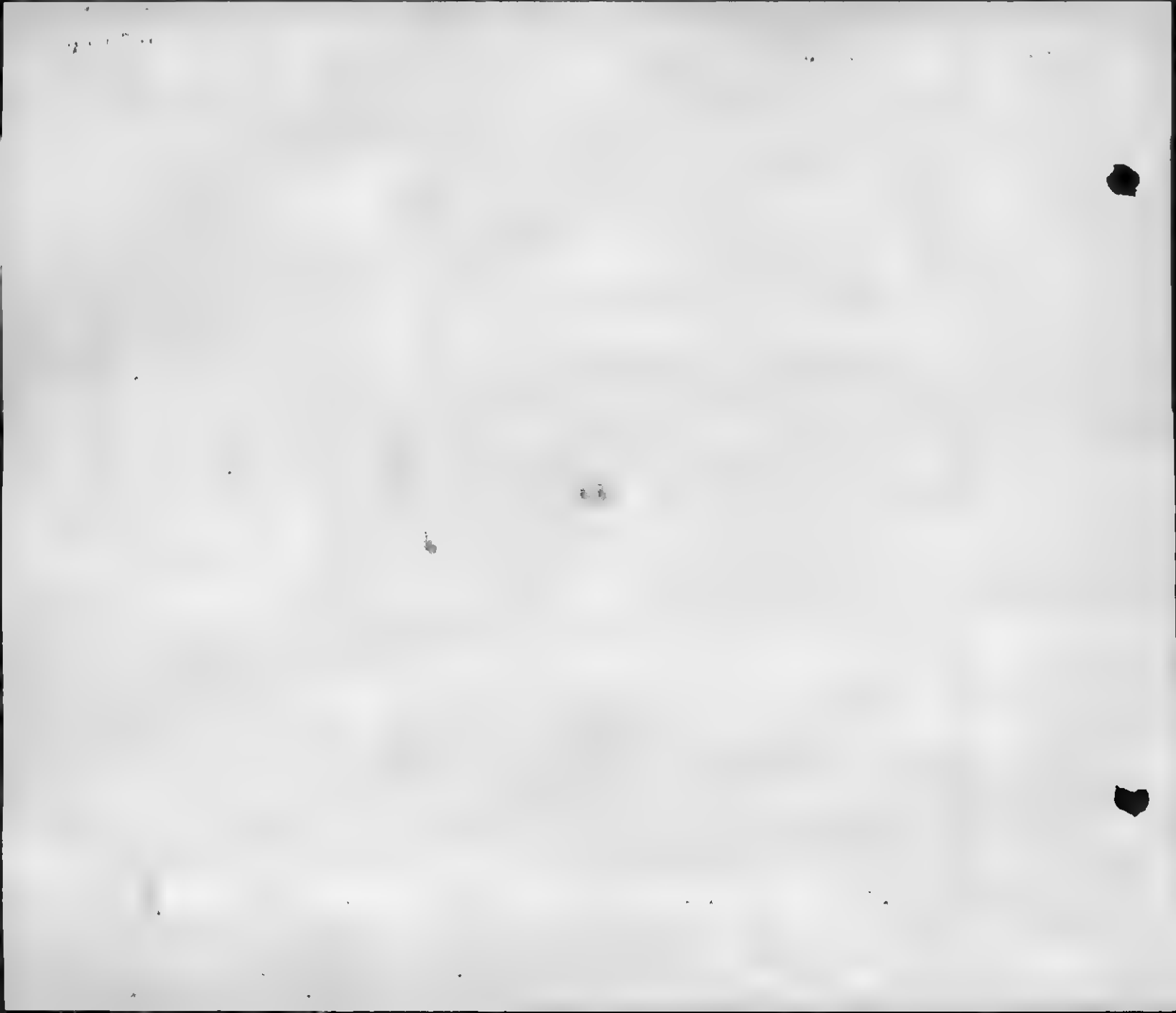
03413

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>6212 Shipview Way</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>RALPH J. KELLAM</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 3, 1955</u>	
5. SEX. <u>Male</u> 6. COLOR OR RACE. <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	
8. DATE OF BIRTH: <u>2/6/94</u>		9. AGE last birthday: <u>61</u> yrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>	
11. BIRTHPLACE (State or foreign country): <u>Anancock, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Tank Kellam</u>		14. MOTHER'S MAIDEN NAME: <u>Bertie Pennywell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>213-12-2200</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE LUNG, RIGHT</u>		Unknown	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
(B)			
(C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION.		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 28, 1955, to April 3, 1955, that I last saw the deceased</u> and that death occurred at <u>8:55A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>William B. VandeGrift, M.D.</u>		ADDRESS <u>M. D. Fort Howard, Maryland</u>	
DATE SIGNED <u>4/4/55</u>			
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Burial</u> <u>APR. 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u> LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <u>Wm. Cook-Blight Inc.</u> ADDRESS <u>6009 Harford Rd. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3438

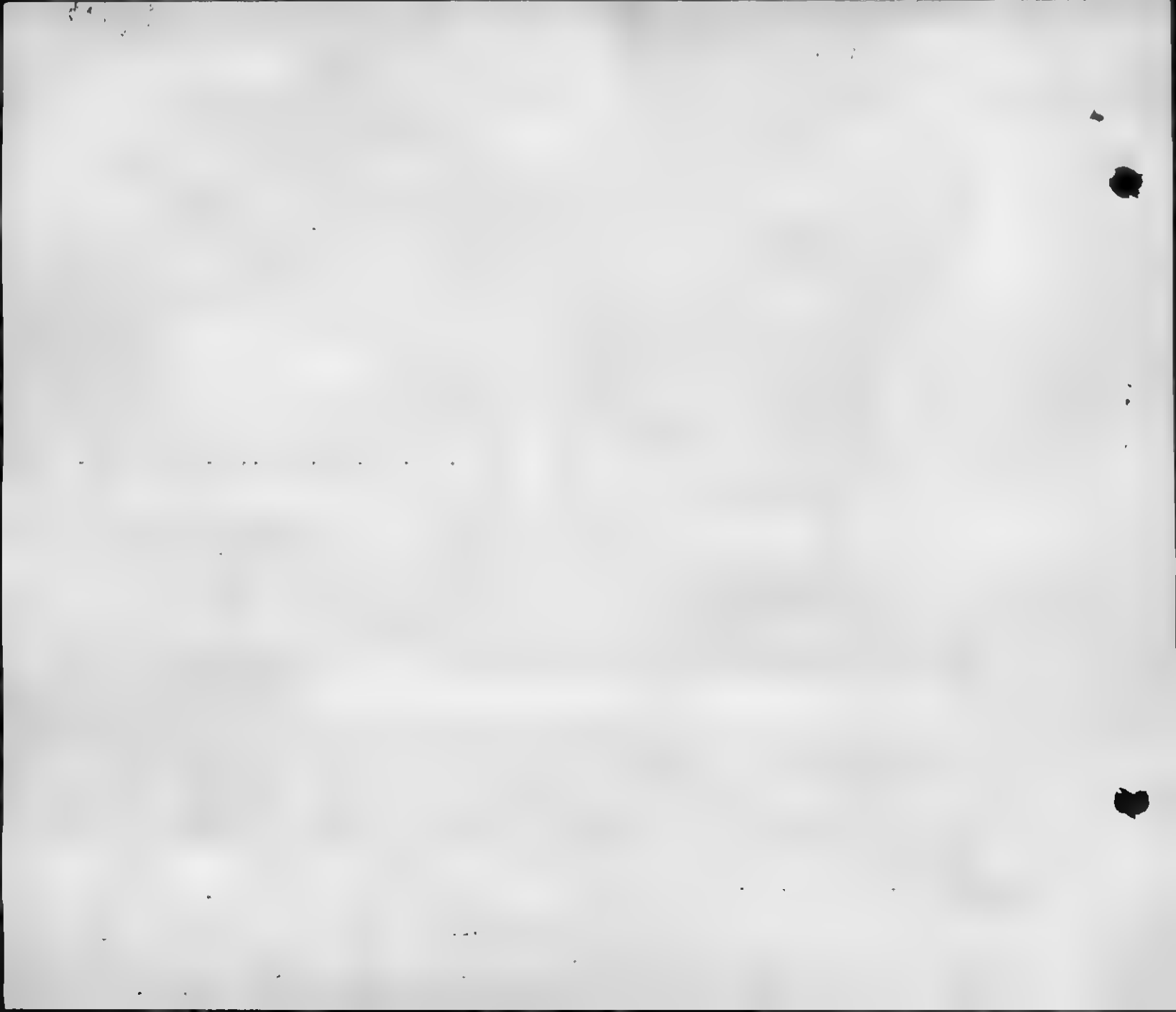
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
TOWN <u>Fort Howard</u>	<u>4 Days</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>919 E. Chase Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>WILLIAM J. KELLY</u>		DATE OF DEATH: <u>April 6 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH.
			9. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
			<u>83</u> yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>OW</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <u>PULMONARY EDEMA</u>		<u>Unknown</u>	
(B) ANTECEDENT CAUSE (S) <u>DUE TO ARTERIOSCLEROTIC CARDIO VASCULAR DIS. DECOMP</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from April 2, 1955, to April 6, 1955, and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
SIGNATURE <u>Irving Freeman, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>4/8/55</u>		DATE SIGNED <u>4/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>APRIL 12, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/11/55</u>		REGISTRAR'S SIGNATURE <u>Dr. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Blight Inc.</u>		ADDRESS <u>6009 Harford Rd. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3439

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>9 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cheverly</u>	<u>1.38</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>	STREET ADDRESS <u>Unknown</u>	(If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Cora King</u>		OF DEATH <u>April 30, 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE last birthday <u>83?</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>422.1</u>			
ANTECEDENT CAUSE (S) <u>(A) Arteriosclerotic cardiovascular disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4-21-</u> , 1955 to <u>4-30-</u> , 1955 that I last saw the deceased alive on <u>4-30-</u> , 1955, and that death occurred at <u>8:50 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		DATE SIGNED <u>4-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>May 5-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Old St Pauls</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE <u>Wm Cook</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>1217 St Paul St</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

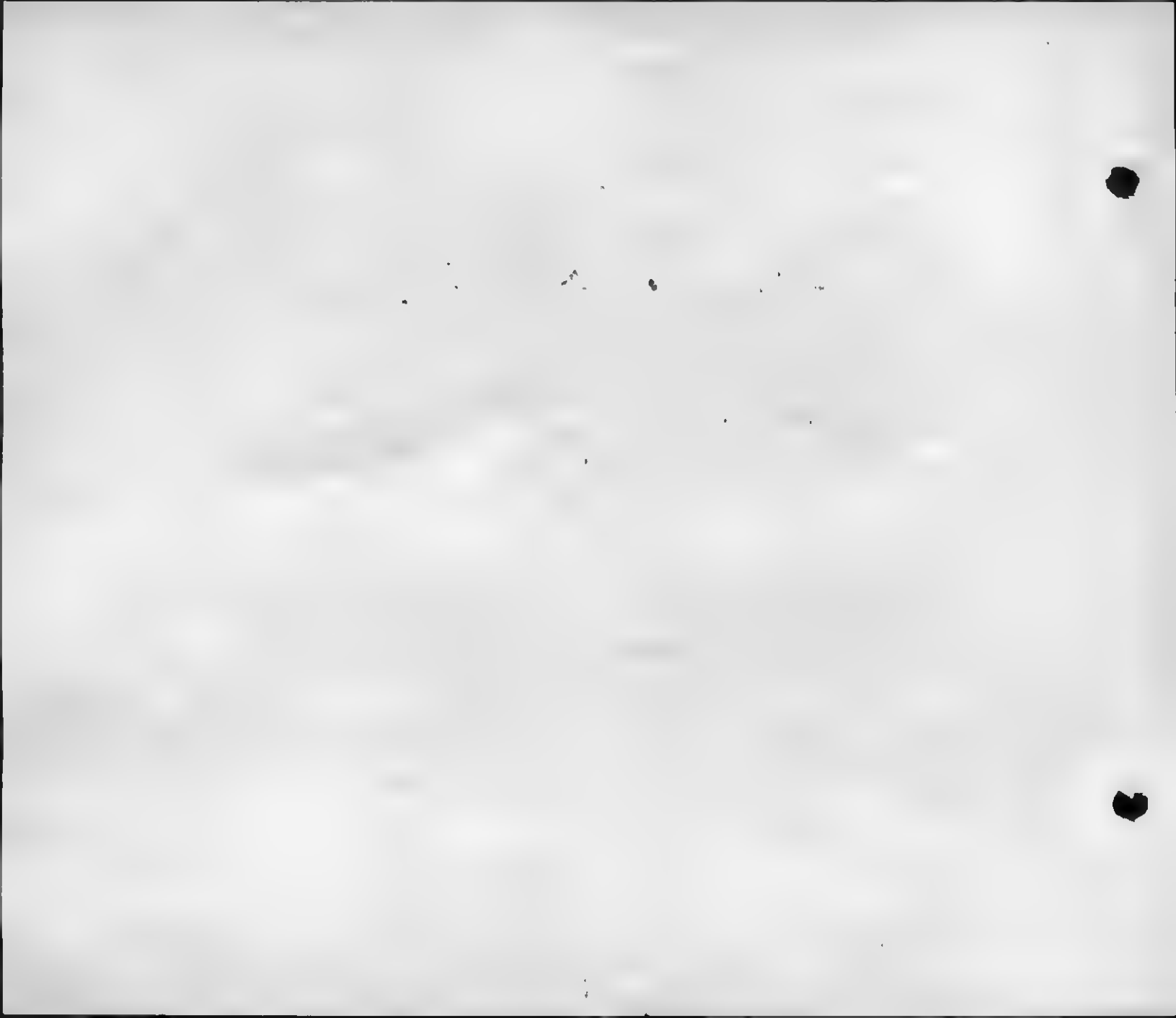
3440 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03416

CERTIFICATE OF DEATH

Reg. Dist. No. 1

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonville</u>	LENGTH OF STAY (in this place) <u>lmo. 25 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>720 "F" Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>ALICE J. KRAMER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 5, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH: <u>12-8-1876</u>
9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Richard J. JAMES.</u>		14. MOTHER'S MAIDEN NAME: <u>Mary V. McFall McFAUL.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-5885</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebrovascular accident</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>		Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-11-</u> , 19 <u>55</u> to <u>4-5-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-5-</u> , 19 <u>55</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>See note of Herschman</u>		ADDRESS <u>M.D. Spring Grove</u>	
DATE SIGNED <u>4-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>	
LOCATION (City, town, or county) (State) <u>Baltimore</u>			
DATE REC'D BY LOCAL REGISTRAR <u>4-6-55</u>		REGISTRAR'S SIGNATURE <u>A. W. O. Glick</u>	
24. FUNERAL DIRECTOR <u>See note of Herschman</u>		ADDRESS <u>108 W. Lombard</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 33

3441

03417

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>UPPER MERIDEN</u> OR TOWN <u>UPPER MERIDEN</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>ARCADIA</u> OR TOWN <u>ARCADIA</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>L - HAZEL - A - LAMOTTE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 24 1955</u>	
5. SEX <u>OH</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-25-1885</u>
9. AGE last birthday <u>70</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Lapp</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Ashe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year of dates of service) <u>Yes</u>		16. SOCIAL SECURITY No. <u>138-26-9678</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Adelaide Jeff - Upper Meriden</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
181X Immediate cause (a) <u>Pyelo-Nephritis</u>		<u>2 mo.</u>	
Antecedent cause(s) (b) <u>Carcinoma of Bladder</u>		<u>2 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>May 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Bladder</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		22. PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>April 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>55</u> , and that death occurred at <u>UPPER MERIDEN</u> m., from the causes and on the date stated above.			
SIGNATURE <u>M.C. Carterfield, M.D.</u>		ADDRESS <u>Hampstead Md</u> DATE SIGNED <u>4/25/55</u>	
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Apr 27/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
DATE REC'D BY LOCAL REG. <u>4-26-55</u>		REGISTRAR'S SIGNATURE <u>Dary B. Elmer</u>	
FUNERAL DIRECTOR <u>Edw. Chilton, Hampstead Md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 7, Film 181 5-23-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK (22)</u>		LENGTH OF STAY (in this place) <u>40 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22, MD</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3601 NORTH POINT BLVD.</u>				STREET ADDRESS (If rural give location) <u>3601 NORTH POINT BLVD.</u>			
3. NAME OF DECEASED: (First) <u>HENRY</u> (Middle) <u>(NM)</u> (Last) <u>LAUBACH</u>				4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>24</u> (Year) <u>1955</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widower</u>		8. DATE OF BIRTH: <u>JAN 10, 1887</u>	
9. AGE last birthday: <u>68</u> yrs.		10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>STEEL FARM</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>FARMING</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>CHRISTIAN LAUBACH</u>			
14. MOTHER'S MAIDEN NAME: <u>MARY (UNK)</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>			
16. SOCIAL SECURITY No.: <u>218-32-4196</u>				17. INFORMANT & ADDRESS: <u>ELIZABETH MILLER - SAME ADDRESS</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<p>422.1 Immediate cause (a) <u>Coronary Thrombosis</u></p> <p>Antecedent causes (s) (b) <u>Coronary arteriosclerosis</u></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause stating the underlying cause last. (c)</p>							
Interval Between Onset And Death <u>Immediate</u>							
2. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1953</u> to <u>212 PM</u> , 1955, that I last saw the deceased alive on <u>21 April</u> , 1955, and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
DATE THEREOF <u>4-27-55</u>		NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		LOCATION (City, town, or county) <u>BALTO. Co., MD.</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>April 26-1955</u>		REGISTRAR'S SIGNATURE <u>William M Kelly</u>		FUNERAL DIRECTOR <u>North Point Burial, Dundalk, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 1955

3442

03419

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 4

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Pa.</i>	COUNTY <i>Lancaster</i>
CITY (If outside corporate limits, write OR and give nearest town) TOWN <i>Jonestown</i>	LENGTH OF STAY (in this place) <i>Visiting</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Jonestown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>3613 Putty Hill Rd.</i>		STREET ADDRESS (If rural, give location) <i>Rt # 2</i>	
3. NAME OF DECEASED: (Type or Print) <i>Claude Milnot Lester Sr.</i>		4. DATE OF DEATH <i>April 11 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Sept 22/1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if outside of work) <i>Barkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Bar</i>	9. AGE last birthday: <i>73</i> yrs.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME: <i>Amanda</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>227-10-5339</i>	
		17. INFORMANT & ADDRESS: <i>MRS W. WANN 3613 PUTTY HILL RD.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate Autopsy</i>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause <i>420.1</i> DUE TO <i>Coronary occlusion</i>	(a).....	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO <i>Cardiovascular disease</i>	(b)..... (c).....	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
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19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town (County) (State)
---	---	-------------------------------------

21d. TIME (Month) (Day) (Year) (Hour) OF DEATH <i>April 11 1955 8 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE <i>M. J. Garrison M.D.</i>	DATE SIGNED <i>APR 14 1955</i>
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23. BURIAL, CREMATION, REMOVAL (Specify): <i>BURIAL</i>	DATE THEREOF <i>APRIL 14 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Wood Lawn</i>	LOCATION (City, town, or county) (State) <i>Bluefield WV</i>
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DATE REC'D BY LOCAL REG. <i>4-11-55</i>	REGISTRAR'S SIGNATURE <i>R. A. Hedgcock</i>	24. FUNERAL DIRECTOR <i>Chas F Evans & Son</i>	ADDRESS <i>8802 Harford Rd.</i>
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MARGIN RESERVED FOR BINDING

VS. A15A-5-53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

3443

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 33

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11. A. T. ...</u>		STREET ADDRESS (If rural, give location) <u>...</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>JESSE</u> (Middle) <u>LEE</u> (Last) <u>Logsdon</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>14</u> (Year) <u>1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>JAN. 26, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>...</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>...</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>...</u>		14. MOTHER'S MAIDEN NAME <u>...</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>...</u>		16. SOCIAL SECURITY NO. <u>218-10-0910</u>	
17. INFORMANT AND ADDRESS <u>...</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
420.1 Immediate cause (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
Antecedent cause(s) (b) <u>Coronary artery disease</u>		<u>3 yr.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic hypertension</u>		<u>1 yr.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 12</u> , 19 <u>54</u> , to <u>Apr 14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr 12</u> , 19 <u>55</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>...</u> (Degree or title)		ADDRESS <u>...</u> DATE SIGNED <u>April 14/1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> DATE <u>April 14/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Stonem Chapel</u> LOCATION (City, town, or county) <u>Pikesville</u> (State) <u>md.</u>	
DATE REC'D BY LOCAL REG. <u>4-14-55</u>		24. FUNERAL DIRECTOR <u>...</u> ADDRESS <u>...</u>	

© 2002

... *Alfred* ... *Alfred* ... *Alfred* ... *Alfred* ... *Alfred* ...

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3444 CERTIFICATE OF DEATH

03421

Reg. Dist. No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>9 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>6301 BROWN AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES E. LUDWIG</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>APRIL 23 1955</u>			
5. SEX. <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>4-17-07</u>	
9. AGE last birthday <u>48</u> yrs. Months Days Hours Min.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FIREMAN</u>			
11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>CHRISTIAN LUDWIG</u>				14. MOTHER'S MAIDEN NAME: <u>THERESA LACKEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES WW II</u>				16. SOCIAL SECURITY NO. <u>907-10-9647</u>			
17. INFORMANT & ADDRESS: <u>CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) <u>MITRAL STENOSIS</u>				12 Years			
ANTECEDENT CAUSE (B) <u>RHEUMATIC HEART DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>APRIL 14, 1955</u> to <u>APRIL 23, 1955</u> and that death occurred at <u>2:30PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>				DATE SIGNED <u>4/24/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</u>			
DATE REC'D BY LOCAL REGISTRAR <u>4-21</u>				REGISTRAR'S SIGNATURE <u>[Signature]</u>			
24. FUNERAL DIRECTOR <u>WILLIAM COOK-ELIGHT, INC. FUNERAL HOME</u>				ADDRESS <u>6009 HALEWOOD ROAD, BALTIMORE 11, MD.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3445

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baldwin</u>	LENGTH OF STAY (in this place) <u>68 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baldwin Rd.</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>58</u>		STREET ADDRESS (If rural give location)	1
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>John Francis Lynch</u>		DATE OF DEATH: <u>Apr 2</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>Sept 5</u>
9. AGE last birthday: <u>68</u> yrs		10. IF UNDER 1 YEAR: <u>6</u> Months	11. IF UNDER 24 HRS: <u>6</u> Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>General Farming</u>	11. BIRTHPLACE (State or foreign country): <u>Baldwin Md.</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: <u>Michael Henry Lynch</u>	
14. MOTHER'S MAIDEN NAME: <u>Ellen Terese Kelly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give year or date of service) <u>with 81st</u>	
16. SOCIAL SECURITY NO. <u>2-10-100000</u>		17. INFORMANT & ADDRESS: <u>Edward X Lynch Baldwin Md</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>		<u>1st</u>	
ANTECEDENT CAUSE (B) <u>Hypertension</u>		<u>Yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1930</u> , to <u>April 2, 1955</u> that I last saw the deceased alive on <u>2/2</u> , 19 <u>55</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Wm J. Hammitt</u> M.D. <u>Baltimore</u>		DATE SIGNED <u>April 3, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-4-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St John Catholic</u>		LOCATION (City, town, or county) (State) <u>Hydes Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <u>Wm J. Hammitt</u> ADDRESS <u>Martin & Kurlitz Fallsville</u>	

MARGIN RESERVED FOR BINDING

100

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03428
3446 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>7514 Brightside Avenue</u>	
3. NAME OF DECEASED: (Type or Print) <u>Emerson Vernon Marchant</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 6, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>10-4-1904</u>
9. AGE last birthday, IF UNDER 1 YEAR: <u>50</u> yrs Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Salesman</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>R. B. Marchant</u>		14. MOTHER'S MAIDEN NAME: <u>Grace Scarborough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown World War II</u>		16. SOCIAL SECURITY NO. <u>212-10-6572</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) <u>Acute coronary thrombosis</u>		<u>Hours</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>DUE TO</u>	
(C) <u>Bronchopneumonia</u>		(C) <u>2 days</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5-21- , 1953 to 4-6- , 1955, that I last saw the deceased alive on 4-6- , 1955, and that death occurred at 9:00 AM from the causes and on the date stated above.			
Signature <u>Spring Grove State Hospital</u>		DATE SIGNED <u>4/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/8/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baito Natl.</u>		LOCATION (City, town, or county) (State) <u>Baito Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/17/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Lansdown Funeral Home 7401 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

VS. A15--10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5501

3447

CERTIFICATE OF DEATH

1. PLACE OF DEATH. <u>606 MILD FORD MILL ROAD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTIMORE COUNTY</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Pikesville</u>	LENGTH OF STAY (in this place) <u>32 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	OR TOWN <u>8</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>606 Mild Ford Mill Road</u>	X
3. NAME OF DECEASED: (First) <u>Joseph</u> (Middle) <u>GIBBONS</u> (Last) <u>MATHER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>APR 11 2 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>NOV. 11, 1883</u>
9. AGE last birthday: <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>	11. BIRTHPLACE (State or foreign country): <u>BALTIMORE MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>		13. FATHER'S NAME: <u>WILLIAM MATHER</u>	
14. MOTHER'S MAIDEN NAME: <u>MARY MCCULLOUGH</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>212-10-7571A</u>		17. INFORMANT & ADDRESS: <u>same address</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
410X IMMEDIATE CAUSE (A) <u>Pneumonia</u>			<u>48 hrs</u>
ANTECEDENT CAUSE (B) <u>Myocardial infarction</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Arterio-sclerotic heart disease</u>			<u>20 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic bronchitis, Pulmonary emphysema</u>			
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>fall</u> , 19 <u>45</u> , to <u>4/11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/1</u> , 19 <u>55</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Reini Salomon</u>		ADDRESS <u>M.D. 1413 Peabody Ave. Rd.</u> DATE SIGNED <u>4/7/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>		LOCATION (City, town, or county) (State) <u>WOODLAWN MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>APR 11 4 1955</u>		REGISTRAR'S SIGNATURE <u>Harvey A. Newell</u>	
24. FUNERAL DIRECTOR <u>FRANK H. NEWELL</u>		ADDRESS <u>Pikesville MD</u>	

MARGIN RESERVED FOR BINDING

S. A. 1111110

80/3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03425
3448 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Parkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural-Parkton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt. Carmel Rd.</u>		STREET ADDRESS (If rural give location) <u>Mt. Carmel Rd.</u>	

3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print)	(First) (Middle) (Last)	(Month) (Day) (Year)	
<u>Blaine Mays</u>		<u>April 20, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWER, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>December 4, 1886</u>
9. AGE last birthday:		10. AGE last birthday:	
<u>68</u> yrs.		<u>68</u> yrs.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.		10b. KIND OF BUSINESS OR INDUSTRY.	
<u>Farmer</u>		<u>Own Farm.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Baltimore Co., Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Robert H. Mays</u>		<u>Carrie A. Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY No.:	
<u>No</u>		<u>Ms Stanley Thompson - Parkton, Md. R.D.</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>422.1</u>		
Immediate cause		
(a) <u>Coronary Heart Failure</u>		<u>1 yr.</u>
DUE TO		
Antecedent causes (s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(b) <u>Arterio Sclerosis C.V. Disease</u>		<u>8 yrs.</u>
DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED	
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR ?	

22. I hereby certify that I attended the deceased from June, 1955, to April 20, 1955, that I last saw the deceased alive on 4-20, 1955, and that death occurred at 6:55 P.M., from the causes and on the date stated above.

SIGNATURE Mamie C. Partriford M.D. ADDRESS Hampstead, Md. DATE SIGNED 4-22-55

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF April 23, 1955 NAME OF CEMETERY OR CREMATORY Hereford Bapt. Cem. LOCATION (City, town, or county) (State) Hereford, Balto., Md.

DATE REC'D BY LOCAL REGISTRAR 5/23/55 REGISTRAR'S SIGNATURE Jacob Fortunstein 24. FUNERAL DIRECTOR'S ADDRESS New Freedom, Pa.

MARGIN RESERVED FOR BINDING

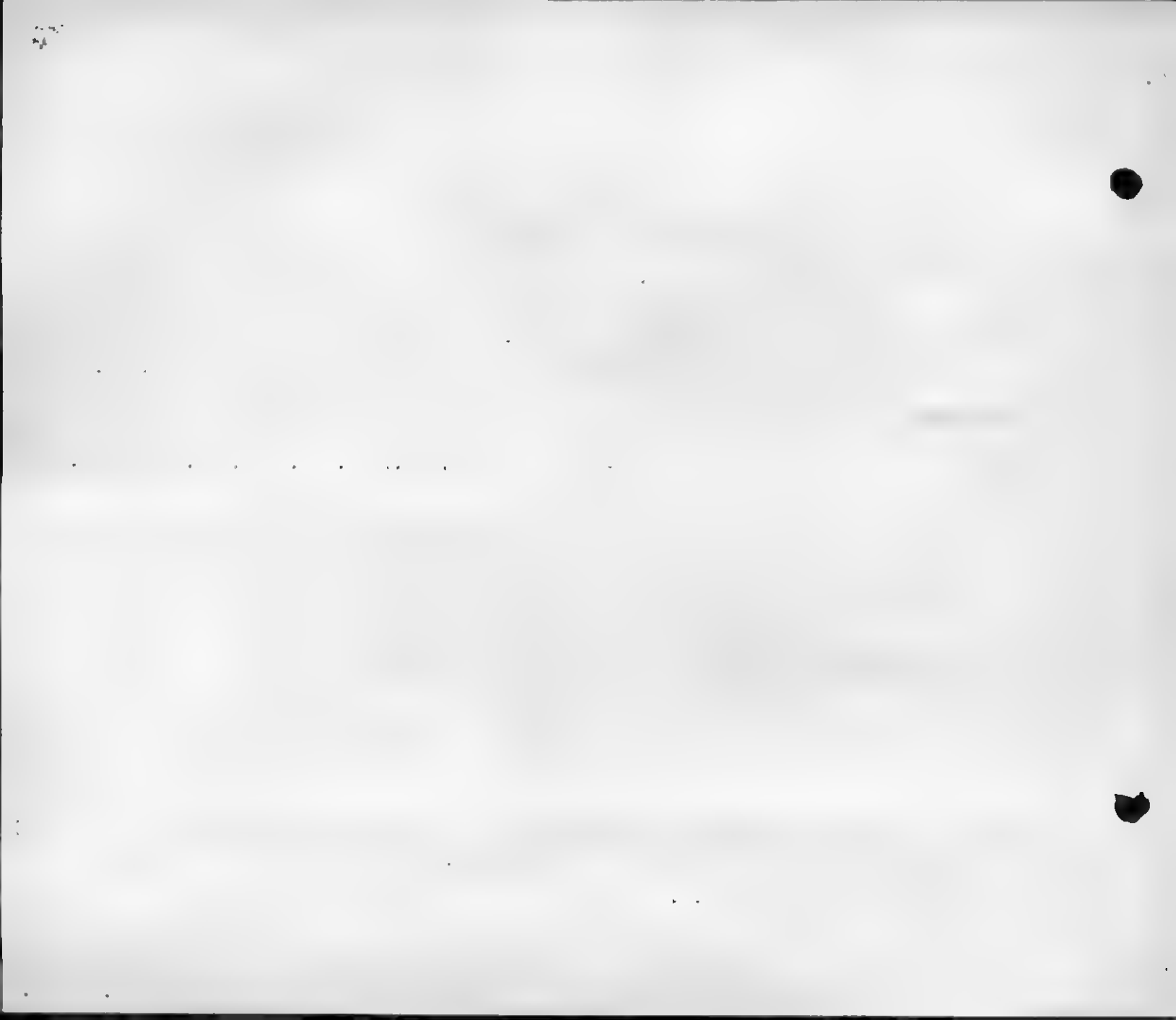
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3449 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03427
CERTIFICATE OF DEATH Reg. Dist. No. ~~X~~

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		STATE <u>MARYLAND</u> COUNTY <u>HOWARD</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WOODSTOCK</u> STREET ADDRESS (If rural give location) <u>WOODSTOCK COLLEGE</u>	
3. NAME OF DECEASED: (Type or Print) <u>WILLIAM C. MC CLOSKEY</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 21 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>SEPTEMBER 9, 1890</u>
9. AGE last birthday, IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (State or foreign country): <u>STATEN ISLAND, NEW YORK</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>CLERK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>MICHAEL . MC CLOSKEY</u>		14. MOTHER'S MAIDEN NAME: <u>MARY VANDERVORT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u> (If Yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO: <u>213-12-6298</u>	
17. INFORMANT & ADDRESS: <u>CLIN.REC., VET.ADM.HOSP., FT.HOWARD, MD.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>165X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA, LEFT LUNG</u> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)		<u>UNKNOWN</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that <u>VA</u> attended the deceased from <u>APRIL 11, 1955</u> , to <u>APRIL 21, 1955</u> , that last saw the deceased <u>XXXXXXXXXXXXXXXXXXXX</u> and that death occurred at <u>9:15A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>WILLIAM B. VANDEGRIFT, M.D.</u>		ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>4-21-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>April 25, 1955</u> NAME OF CEMETERY OR CREMATORY <u>ALPHONSUS CEMETERY</u> LOCATION (City, town, or county) (State) <u>WOODSTOCK, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-22-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Armocost, Ellsworth, Funeral Chapel</u>		ADDRESS <u>4600 Liberty Heights Avenue, Balto., Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

3450

CERTIFICATE OF DEATH

03428
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 502 INGLESIDE AVE.		STREET ADDRESS (If rural, give location) 502 INGLESIDE AVE.	
3. NAME OF DECEASED (Type or Print)	(First) ANNA	(Middle) MARIE	(Last) MC KEE
4. DATE OF DEATH	(Month) APRIL	(Day) 25	(Year) 1955
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH AUG. 8, 1877
9. AGE last birthday 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN MC KEE		14. MOTHER'S MAIDEN NAME NOT KNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mr. Joseph Welch 501 Ingleside Ave.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) Cerebral Arterio Sclerosis		2 1/2 hrs
Antecedent cause(s) (b) Generalized Arterio Sclerosis		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arterio Sclerosis C.V.S.		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Aug 1, 1934 to Apr 25, 1955 , that I last saw the deceased alive on Apr 24, 1955 , and that death occurred at 6 A.M. from the causes and on the date stated above.				
SIGNATURE James E. Howell		ADDRESS Catonville		DATE SIGNED 4-26
23. BURIAL, CREMATION REMOVAL (Specify)	DATE 4-27-55	NAME OF CEMETERY OR CREMATORY Cathedral Cem.	LOCATION (City, town, or county) Balto.	(State) MD.
DATE REC'D BY LOCAL REG. 4/26/55	REGISTRAR'S SIGNATURE V.E. Harry	24. FUNERAL DIRECTOR Shelby Funeral Home, Catonsville, Md.		

MARGIN [EVEN] FOR BINDING

2000

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3451 CERTIFICATE OF DEATH

03429

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>7 MONTHS</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> 3001.4 STREET ADDRESS <u>3902 SOUTHERN AVE. BALTIMORE 6, MD.</u>	
3. NAME OF DECEASED (Full) (Middle) (Last) NORA LUTZ MCKENZIE		4. DATE (Month) (Day) (Year) OF DEATH <u>APRIL 2 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>W</u>	8. DATE OF BIRTH <u>JULY 1870</u>
9. AGE last birthday <u>84</u> yrs		10. MONTHS <u>8</u> DAYS <u>4</u> HOURS <u>1</u> MIN.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>UNK</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>UNK</u>	
13. FATHER'S NAME: <u>CHARLES G. Lutz</u>		14. MOTHER'S MAIDEN NAME: <u>ANNE N. Bopst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>	
17. INFORMANT & ADDRESS <u>MISS BLANCHE LUTZ</u> <u>3540 BEECH AVE., BALT. MD.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROSIS</u>			
ANTECEDENT CAUSE (S) <u>SENILITY</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG. 1954</u> to <u>APR. 2, 1955</u> that I last saw the deceased alive on <u>APR. 2, 1955</u> , and that death occurred at <u>11 PM.</u> from the causes and on the date stated above.			
SIGNATURE <u>Benjamin Blackman</u> M.D.		DATE SIGNED <u>4/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-6-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>		LOCATION (City, town, or county) (State) <u>Rockland Howard Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-4-55</u>		24. FUNERAL DIRECTOR <u>Howard Strong</u> ADDRESS <u>3207 W. North Ave.,</u>	



3452

MARYLAND STATE DEPARTMENT OF HEALTH

03430

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Notch CLIFF Road.</u>		STREET ADDRESS (If rural, give location) <u>3102 Pelham Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George Walter McNeill</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 1 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 24, 1928</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practitioner - Bethlehem Steel</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>27 yrs.</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A McNeill</u>		14. MOTHER'S MAIDEN NAME <u>M Elizabeth Blank</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr George A McNeill SAME</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>976x Immediate cause (a) Gunshot Wound in Heart</u>		<u>Sudden</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		<u>About midnight</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>Seen by</u>
19a. DATE OF OPERATION		<u>Medical Examiner</u>
19b. MAJOR FINDINGS OF OPERATION		<u>at 2:25 am.</u>
20. AUTOPSY?		
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. PRIMARY OR CONTRIBUTING CAUSE OF DEATH		
TIME (Month) (Day) (Year) (Hour) OF INJURY		
PLACE (Home, farm, factory, street, or office bldg., etc.) OF INJURY		
INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described at the Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.

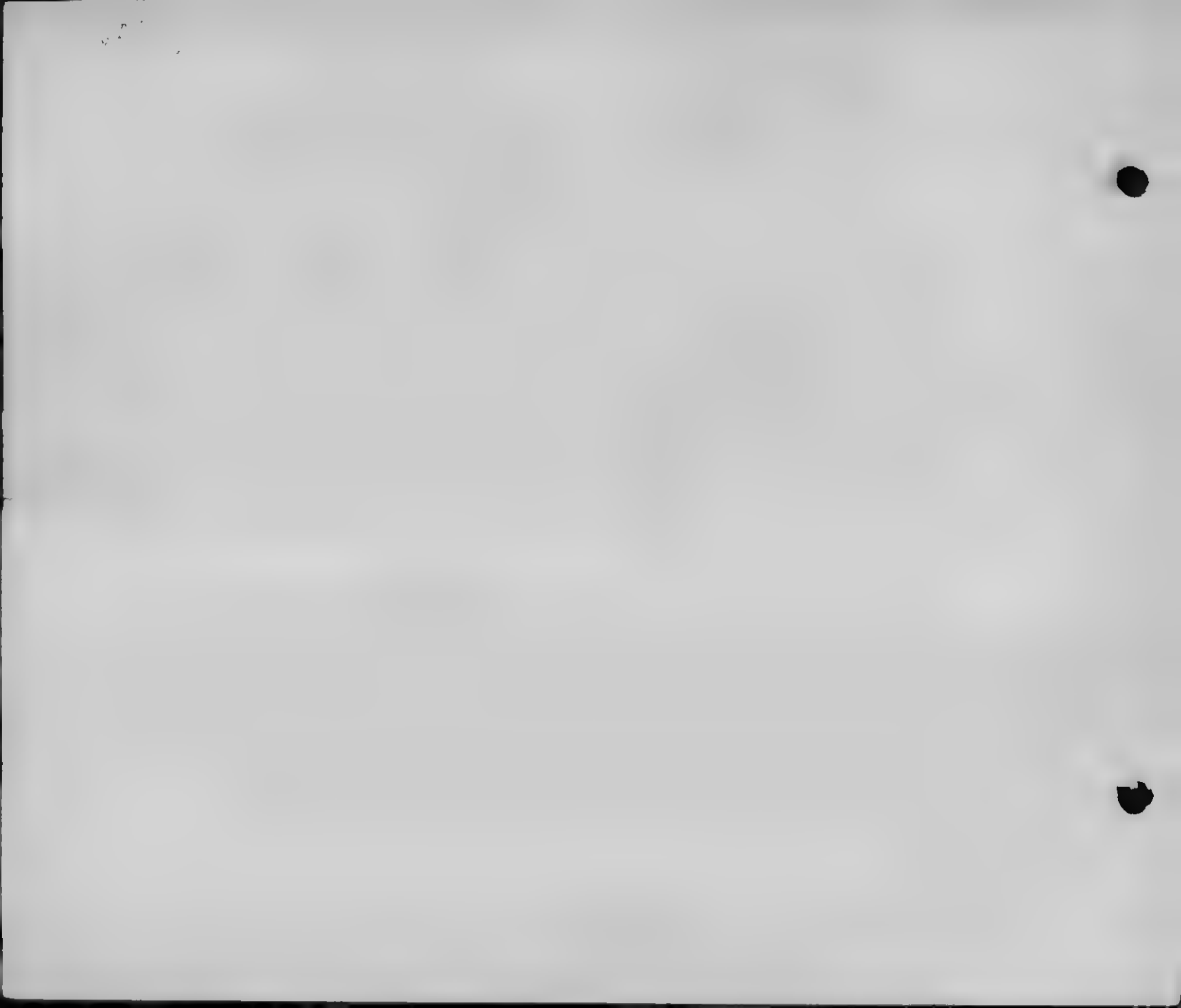
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Charles F O'Donnell MD 7501 York Rd Towson 4/1/57

23. CREMATION (State) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)
Burial 4-4-55 Holy Redeemer BALTO Md

24. FUNERAL DIRECTOR ADDRESS
4-1-55 R L V. Hedrick Leonard J Ruck 5305 Bayford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.



3453

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Fort Howard</u> TOWN <u>Fort Howard</u>	MARYLAND LENGTH OF STAY (in this place) <u>8 Hrs. 15 Min.</u>	STATE <u>Maryland</u> COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> TOWN <u>Baltimore</u>	STREET ADDRESS (If rural give location) <u>2329 Madison Avenue</u>
3. NAME OF DECEASED: (Type or Print) <u>THOMAS L. MILBURN</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>April 29, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>7/6/93</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Waiter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Hotel</u>	
13. FATHER'S NAME: <u>Charles H. Milburn</u>		14. MOTHER'S MAIDEN NAME: <u>Annabelle Yates</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.: <u>212-10-7471</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u>		<u>1 MONTH</u>	
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u>		<u>7 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?		<u>11:00 AM</u> <u>7:45 PM</u>	
22. I hereby certify that I attended the deceased from <u>Apr. 29, 1955</u> to <u>Apr. 29, 1955</u> , that I last saw the deceased <u>at 7:45 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Louis F. Hubener, M.D.</u>		DATE SIGNED <u>1/30/55</u>	
23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>Holland Funeral Home</u>	
		<u>1631 Druid Hill Ave., Balto., Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03432
3454
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balt.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2415 Poplar Drive</u>	MARYLAND LENGTH OF STAY (in this place)	STATE <u>MD</u> COUNTY <u>B. +</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> STREET ADDRESS (If rural give location) <u>2415 Poplar Drive</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>KATHARINE C. MILLER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 29, 1955</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Dec. 25, 1876</u>
9. AGE (last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Maccubbin</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Mrs. W. A. Trautman-2415 Poplar Drive</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE		(A) <u>Cardio-vascular-renal disease</u>	
ANTECEDENT CAUSE (S)		(B) <u>Myocarditis and arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 17, 1955</u> , to <u>April 29, 1955</u> , that I last saw the deceased alive on <u>April 28, 1955</u> , and that death occurred at <u>8:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>L. J. Tolomek M.D.</u>		ADDRESS <u>4710 Liberty Hts</u> DATE SIGNED <u>May 2 '55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/2/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Green Mount Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedgcock</u>	
FUNERAL DIRECTOR <u>Wm. J. Pickney & Sons</u>		ADDRESS <u>17</u>	

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3455

CERTIFICATE OF DEATH

Reg. Dist. No. 03433

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTIMORE	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town)	OR	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
TOWN	FORT HOWARD	TOWN	BALTIMORE
HOSPITAL OR INSTITUTION OR STREET ADDRESS	VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS	417 CHARTER OAK AVENUE
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
WALTER G. MULLEN		DEATH: APRIL 14 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH.
MALE	WHITE	MARRIED	OCTOBER 16, 1882
9. AGE last birthday		10. IF UNDER 1 YEAR	
72 yrs.		Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
ENGINEER		ELECTRICAL	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
BALTIMORE, MARYLAND		U. S. A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
GREGORY MULLEN		HELEN E. DONNELLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
YES WW-I		UNKNOWN	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MARYLAND		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		2. UNKNOWN	
443X IMMEDIATE CAUSE		(A) HYPERTENSIVE CARDIOVASCULAR DISEASE	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)	
DUE TO		(C)	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
VA M.		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from APR. 12, 1955, to APR. 14, 1955, and that death occurred at 5:15 PM from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
WILLIAM B. VANDEGRIFT, M.D.		M. DYAH, FORT HOWARD, MARYLAND 4-15-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
BURIAL		4-16-1955	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
LOUDON PARK CEMETERY		BALTIMORE, MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
APR 15 - 53		HENRY W. JENKINS & SONS CO., INC.	
REGISTRAR'S SIGNATURE		4905 YORK RD & ROSSITER AVE. BALTIMORE, MD	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03434
3456 CERTIFICATE OF DEATH

Reg. Dist. No. 39

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR
TOWN <u>Rural Monkton</u>	<u>70 YRS</u>	TOWN <u>Monkton</u>	✓
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Manor Road.</u>		<u>Manor Road.</u>	<u>1</u>
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Howard</u>	(Middle) <u>Guy</u>	(Last) <u>Nelson.</u>	OF DEATH: <u>APRIL 8 1955</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>19 FEB 1885</u>
		9. AGE last birthday: <u>70</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>FARMER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME: <u>Howard Nelson</u>		14. MOTHER'S MAIDEN NAME: <u>Florence Parker.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <u>MRS. Guy Nelson - Monkton, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>470X Bilateral Pneumonia</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Advanced Bronchiectasis</u>		<u>3 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept</u> , 1954, to <u>8 April</u> , 1955, that I last saw the deceased alive on <u>8 April</u> , 1955, and that death occurred at <u>9 P. M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Thomas A. Mowley</u>		ADDRESS <u>M. D. Cockeysville, Md.</u>	
DATE SIGNED <u>8 April 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-11-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. James</u>		LOCATION (City, town, or county) (State) <u>Monkton, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 9, 55</u>		REGISTRAR'S SIGNATURE <u>M. Elizabeth Gouch</u>	
FUNERAL DIRECTOR <u>Brooks Funeral Home, Sparks, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES

APR 2 1964

100-100000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3457 CERTIFICATE OF DEATH

03435

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore MARYLAND				STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson LENGTH OF STAY (in this place)				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson 55			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 914 Locust Vale Drive				STREET ADDRESS (If rural give location) 914 Locust Vale Drive Apt 4			
3. NAME OF DECEASED: (First) Mr. Robert (Middle) Theodore (Last) Neumann				4. DATE (Month) (Day) (Year) OF DEATH: April 3rd 1955			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Jan. 24, 1911		9. AGE last birthday 44 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Elect. Maint. Kaiser				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME: Mr. Theodore Neuman n			
14. MOTHER'S MAIDEN NAME: Emma Aumann				15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO 220-05-9052				17. INFORMANT & ADDRESS: Mrs. Mary B. Neuman, 914 Locust Vale Dr.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary artery occlusion						6 hours	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/3, 1955 , to 4/3, 1955 , that I last saw the deceased alive on 4/3, 1955 , and that death occurred at 8 A M, from the causes and on the date stated above.							
SIGNATURE Maddeus C. Swinski				ADDRESS M.D. 17 W. Parma Ave. Towson		DATE SIGNED 4/4/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 6, 1955		NAME OF CEMETERY OR CREMATORY Park wood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-5-55		REGISTRAR'S SIGNATURE E. W. H. H. H.		24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14		ADDRESS	

Dr. Thaddeus Siwinski
17 W. Pennsylvania Ave.
VA 5 3080

10:30 M-N

Released by Dr. R.S. Hudson DME.
Townsend Ind.

3458

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1530 Taylor Avenue		STREET ADDRESS (If rural give location) 1530 Taylor Avenue	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) Mr. Calvin	(Middle) Roache	(Last) Norris	DATE OF DEATH: April 3, 1955
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Oct. 1, 1903
9. AGE last birthday 51 yrs.		10. MONTHS 1 DAYS 1 HOURS 1 MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner Tropical Fish Store		10B. KIND OF BUSINESS OR INDUSTRY: Hagerstown, Maryland	
11. BIRTHPLACE (State or foreign country): USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: ?		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-32-6553	
17. INFORMANT & ADDRESS: Mrs. Vera A. Norris 1530 Taylor Ave.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) CORONARY THROMBOSIS		2 HRS	
ANTECEDENT CAUSE (B) CORONARY ARTERIOSCLEROSIS		17 YRS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/31, 1947 to 4/3, 1955 that I last saw the deceased alive on 4/3, 1955 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
SIGNATURE Robert D. Sunday		M.D. 4/4/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 6, 1955	
NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 4-5-55		REGISTRAR'S SIGNATURE R. W. H. H. H.	
24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Stuart Sunday
Calvert & 33rd Street
9 - 11 Monday.

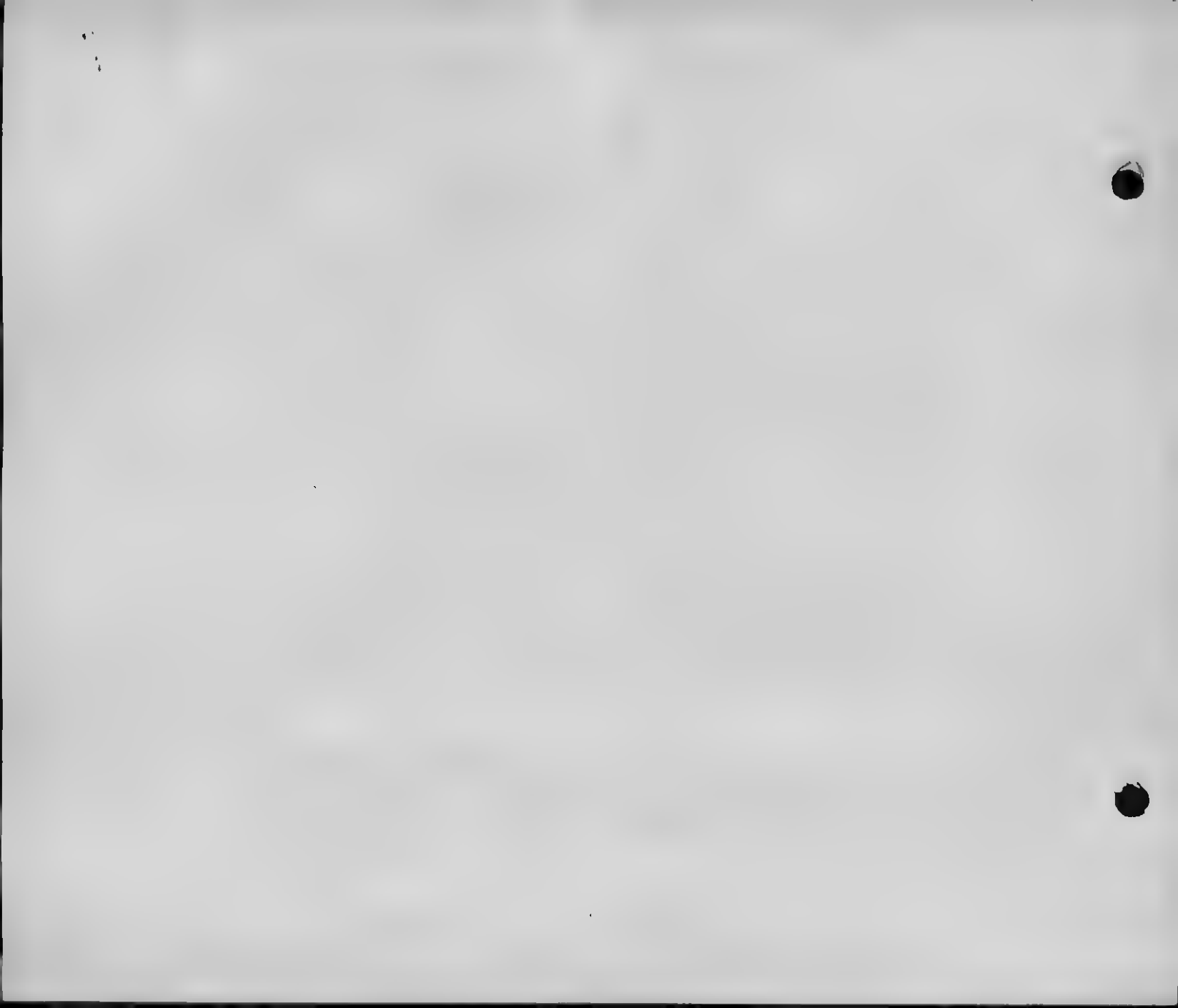
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3459

03437
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>Md.</i>	COUNTY <i>Balto.</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Eatonville</i>	LENGTH OF STAY (in this place) <i>13 da</i>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove Hosp</i>		STREET ADDRESS (If rural, give location) <i>3214 St Paul St.</i>	
3. NAME OF DECEASED: (Type or Print) <i>GEORGIA SCHRYVER PARRISH</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>apr 8 1955</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH: <i>Feb 19, 1871</i>
9. AGE last birthday: <i>84</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>unknown</i>	
11. BIRTHPLACE (State or foreign country): <i>unknown</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Edgar M Schryver</i>		14. MOTHER'S MAIDEN NAME: <i>Louisa Burns</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>NONE</i>	
17. INFORMANT & ADDRESS: <i>Chas. H. Parrish Balto, Md.</i>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)..... DUE TO <i>Senility & generalized arteriosclerosis</i>		<i>2 yrs.</i>	
Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO <i>Fractured Pelvis</i>		<i>1 mo.</i>	
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>none</i>			
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDING OF OPERATION: <i>none</i>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Home</i>	21c. (City or town) (County) (State) <i>Balto. Md.</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>mar 12 '55 7 M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Fell</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>A. D. Caples</i>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <i>4-8-55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Buried</i>	DATE THEREOF <i>4/11/55</i>	NAME OF CEMETERY OR CREMATORY <i>Dried Ridge Cemetery</i>	LOCATION (City, town, or county) (State) <i>Pikesville, Md.</i>
DATE REC'D BY LOCAL REG. <i>4/11/55</i>	REGISTRAR'S SIGNATURE <i>A. D. Caples</i>	FUNERAL DIRECTOR ADDRESS <i>Wm. Cook Inc., 1212 St. Paul</i>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3364 CERTIFICATE OF DEATH

03438

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>OAK PARK</u>		<u>4 YRS.</u>		OR TOWN <u>OAK PARK</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1905 SHERWOOD RD</u>				STREET ADDRESS (If rural give location) <u>1905 SHERWOOD RD.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>BARBARA</u>		(Middle) <u>PAYER.</u>		(Last)	
4. DATE OF DEATH:		(Month) <u>APRIL</u>		(Day) <u>8</u>		(Year) <u>1955</u>	
5. SEX. <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>SEPT. 18, 1892</u>	
9. AGE last birthday: <u>62</u> yrs.		IF UNDER 1 YEAR: Months		IF UNDER 24 HRS. Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>HUNGARY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>THOMAS SLATER</u>			
14. MOTHER'S MAIDEN NAME: <u>EMILY BETA KREIPLER</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT & ADDRESS: <u>ANNA KRALICK 1905 SHERWOOD RD</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Scirrhus Carcinoma of Stomach</u>						<u>14 mos.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>9/10/54</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Scirrhus Carcinoma of Stomach inoperable</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 24, 1953</u> , to <u>APRIL 8, 1955</u> , that I last saw the deceased alive on <u>APRIL 8, 1955</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. Arthur Kossberg</u>		ADDRESS <u>2436 WASHINGTON BLVD. BALTIMORE 30 Md.</u>		DATE SIGNED <u>4/19/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>4/11/55</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 11 55</u>		REGISTRAR'S SIGNATURE <u>Ger Kieffer</u>		24. FUNERAL DIRECTOR ADDRESS <u>Joseph J. Ambrose Jr. 1225 Superior St. Rd.</u>			

24300

RECEIVED

195

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 37

3460

03439

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Sparks</u> LENGTH OF STAY (in this place) <u>lifetime</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sparks</u> <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		STREET ADDRESS (If rural give location) <u>Belfast Road</u> <u>1</u>	
3. NAME OF DECEASED (First) <u>Nellie</u> (Middle) <u>Wheeler</u> (Last) <u>Pearce</u>	4. DATE OF DEATH (Month) <u>April</u> (Day) <u>21</u> (Year) <u>1955</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 7 1889</u>
9. AGE last birthday <u>65</u> yrs.		If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Evan David Wheeler</u>		14. MOTHER'S MAIDEN NAME <u>Ida Rebecca Skippen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>Ida Pearce McKee</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X Immediate cause (a) Carcinoma stomach with metastases

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____

(c) _____

INTERVAL BETWEEN ONSET AND DEATH
1 year

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>July 26 1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of stomach with metastases</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 13, 1954, to April 21, 1955, that I last saw the deceased

alive on Dec. 1-20, 1955, and that death occurred at 9:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Elizabeth B. Merrill, M.D. ADDRESS Cockeysville, Md. DATE SIGNED 4/21/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>April 4-24-55</u>	NAME OF CEMETERY OR CREMATORY <u>Bosley's Methodist</u>	LOCATION (City, town, or county) <u>Sparks, Md.</u>
DATE REC'D BY LOCAL REG. <u>23 April 1955</u>	REGISTRAR'S SIGNATURE <u>Ann Amistead MacPae</u>	24. FUNERAL DIRECTOR <u>Brophy Funeral Home</u>	ADDRESS <u>Sparks, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 23 1955

158-1010

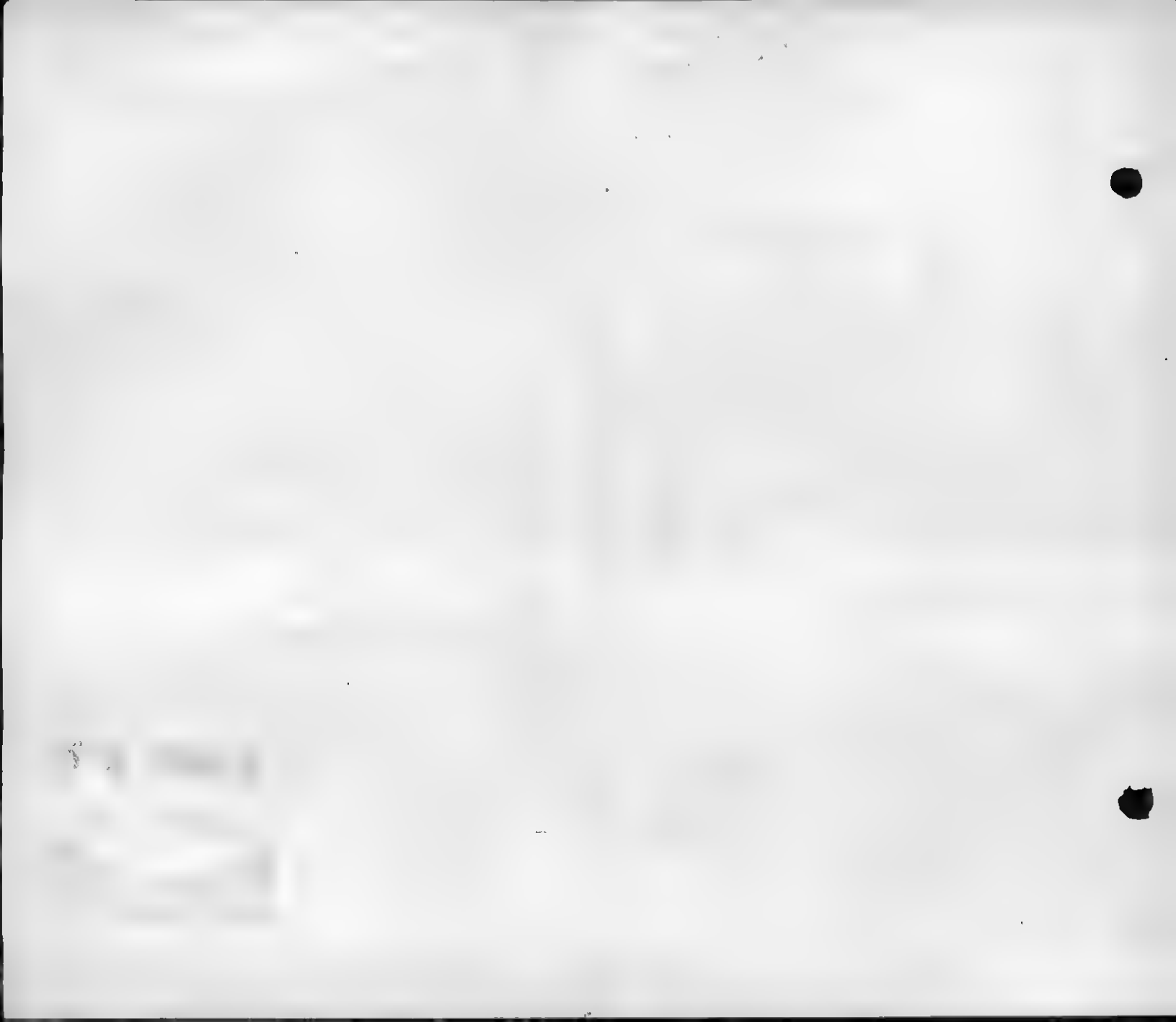
3461 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	MARYLAND LENGTH OF STAY (in this place) <u>2yr. 1mo. 25days</u>	STATE <u>Maryland</u> COUNTY <u>3461-4</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR</u> TOWN <u>Baltimore</u> STREET ADDRESS (If rural give location) <u>505 Cathedral Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>Elienora Murray Peck</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 7, 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>1-27-1870</u>
9. AGE last birthday: <u>85</u> yrs		10. AGE last birthday IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>George H. Murray</u>		14. MOTHER'S MAIDEN NAME: <u>Dora Purinton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMATION & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Myocardial Infarction</u>		DUE TO	
(B) <u>Coronary arteriosclerosis</u>		DUE TO	
(C) <u>Generalized arteriosclerosis</u>		DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPEY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLY NG <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-13-</u> , 1953, to <u>4-7-</u> , 1955 that I last saw the deceased alive on <u>4-7-</u> , 1955, and that death occurred at <u>10:45 M.</u> from the causes and on the date stated above.			
23. SIGNATURE <u>Wachser</u>		DATE SIGNED <u>4-7-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>april 8-1955</u>		NAME OF GEMETERY OR CREMATORY <u>Greenmount</u>	
DATE, REC'D BY LOCAL REGISTRAR: <u>APR 8-1955</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc - 12, 7 St Charles</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 03441

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>ME</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK (221)</u>	LENGTH OF STAY (in this place) <u>28 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ME</u>	<u>1</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1809 PORTSHIP Rd.</u>		STREET ADDRESS <u>#1</u>	(If rural give location) <u>MS</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print) <u>ROBERT</u>	First, (Middle) (Last) <u>N. J. PETERS</u>	(Month) (Day) (Year) <u>4-1-1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>OCT. 13, 1925</u>
9. AGE last birthday: <u>29</u> yrs.		10. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11. USUAL OCCUPATION Give kind of work done during most of working life, even if retired <u>CHERICAL</u>		12. KIND OF BUSINESS OR INDUSTRY: <u>CITY ADMINISTRATION</u>	
13. FATHER'S NAME: <u>ROBERT W. H. PETERS</u>		14. MOTHER'S MAIDEN NAME: <u>LOUISA B. KOHLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY No.: <u>NONE</u>	
17. INFORMANT & ADDRESS: <u>DORA A. PETERS - 1809 PORTSHIP Rd.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>150X</u> Immediate cause (a) <u>Carcinoma of Esophagus</u> DUE TO Antecedent causes (b) <u>None</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last, (c) <u>None</u>		<u>1 yr.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Generalized Atherosclerosis</u>		16 yr.
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-25, 1955, to 4-1, 1955, that I last saw the deceased alive on 3-30, 1955, and that death occurred at 7:30 AM, from the causes and on the date stated above.

SIGNATURE <u>Jack C. Collins, M.D.</u>		ADDRESS <u>2 Kniskip Rd. Balt 22</u>		DATE SIGNED <u>4-1-55</u>
23. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-4-55</u>	NAME OF CEMETERY OR CREMATORY <u>WILMINGTON</u>	LOCATION (City, town, or county) <u>ELKIDGE, MD.</u>	(State) <u>MD.</u>
DATE REC'D BY LOCAL REGISTRAR <u>April 2-1955</u>	REGISTRAR'S SIGNATURE <u>William M. Kelly</u>	24. FUNERAL DIRECTOR <u>James H. Kelly</u>		ADDRESS <u>1000 E. Baltimore Ave. Balt.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U. S. A.

MARYLAND

3462

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 31

Item 3: film 0181 5-12-55 L

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) LOCHEARN		CITY (If outside corporate limits, write RURAL and give nearest town) LOCHEARN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3800 LOCHEARN DR.		STREET ADDRESS (If rural, give location) 3800 LOCHEARN DR.	
3. NAME OF DECEASED (First) ANTOINETTE (Middle) PILIPAUSKAS (Last) AS PILL		4. DATE OF DEATH (Month) APR. (Day) 29 (Year) 1955	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH FEB. 14, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	9. AGE last birthday 74 yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME ANULIS		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS MRS MILTON WATTS, 3800 LOCHEARN DR.			

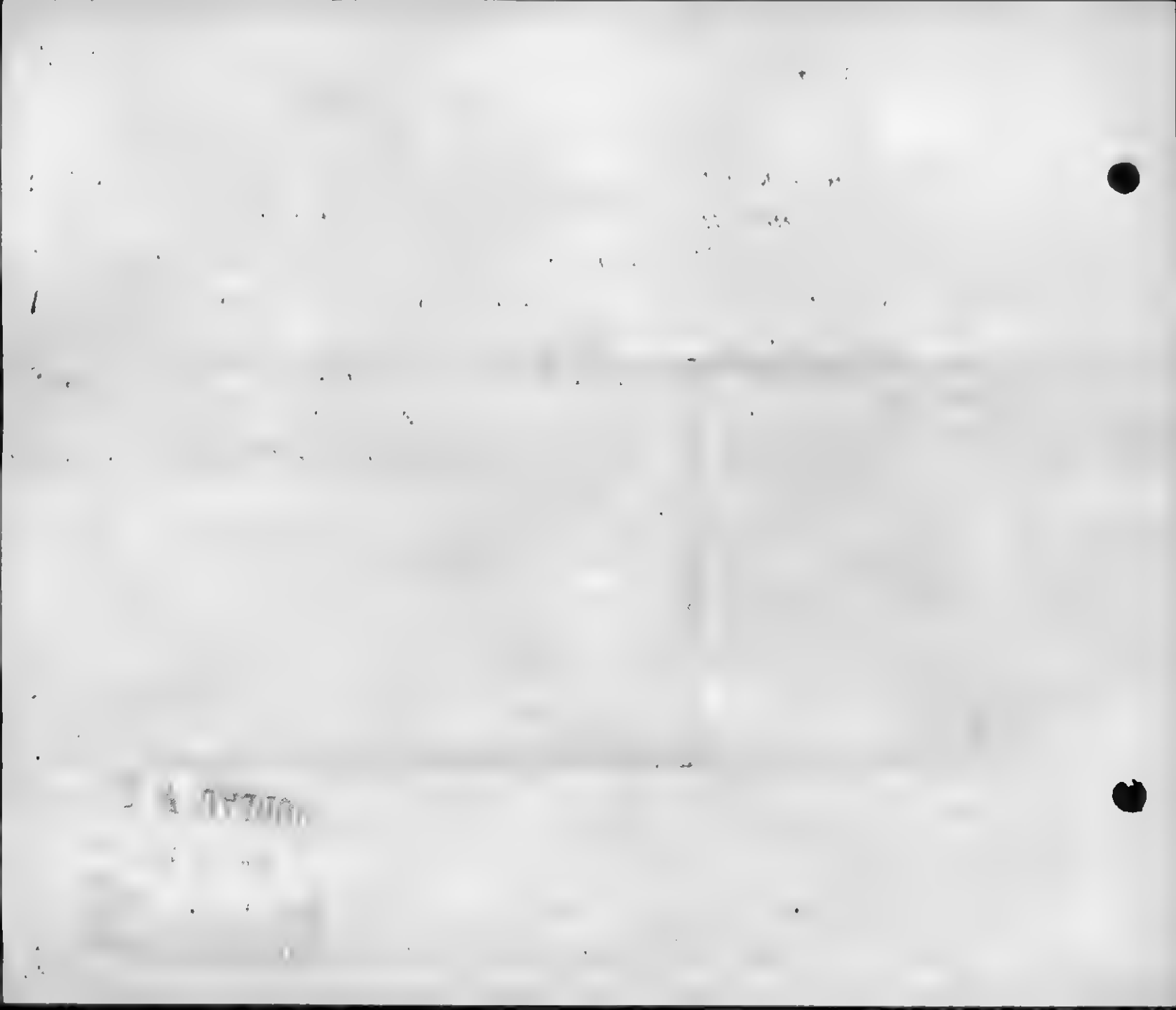
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Acute Cardiac Failure				1 da	
Antecedent cause(s) (b) Cardiovascular Renal Disease				1 yr	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1/10**, 19**55**, to **4/29**, 19**55**, that I last saw the deceased alive on **4/29**, 19**55**, and that death occurred at **6:30** a.m., from the causes and on the date stated above.

SIGNATURE Joseph S. Lawkarts		ADDRESS 6791 Washington Blvd Balto 30		DATE SIGNED 4/29/55	
23. BURIAL OR CREMATION REMOVED (Specify)		NAME OF CEMETERY OR CREMATORY LOU DON PARK		LOCATION (City, town, or county) BALTO. MD.	
DATE REC'D BY LOCAL REG. 5-1-55		REGISTRAR'S SIGNATURE Wigold		24. FUNERAL DIRECTOR'S ADDRESS Harry H. Wigold 4101 EDMONDSON AVE.	

MARGIN RESERVED FOR BINDING



3365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Halethorpe</i>	LENGTH OF STAY (in this place) <i>10 yrs</i>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Halethorpe</i>	<i>51</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1717 Park ave</i>		STREET ADDRESS (If rural, give location) <i>1717 Park ave</i>	<i>1</i>
3. NAME OF DECEASED:		4. DATE OF DEATH	
(Type or Print)	(First) <i>Eugene</i> (Middle) <i>Louis</i> (Last) <i>Plankner</i>	(Month) <i>April</i> (Day) <i>11</i> (Year) <i>1953</i>	
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>	8. DATE OF BIRTH: <i>Sept 30 1886</i>
		9. AGE last birthday: <i>98</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Home</i>	11. BIRTHPLACE (State or foreign country): <i>Balto Md</i>
13. FATHER'S NAME: <i>August S. Schaar</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Hoffman</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <i>no</i>		17. INFORMANT & ADDRESS: <i>Chas. D. Garbelle 1717 Park ave</i>	
16. SOCIAL SECURITY No.: <i>no</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <i>Acute Cardiac failure</i> DUE TO			
Antecedent cause(s) (b) <i>Cardio Vascular disease</i> DUE TO			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Dr. J. M. Kieffer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>April 12 53</i>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>4-14-53</i>	NAME OF CEMETERY OR CREMATORY: <i>Greenwood Park</i>	LOCATION (City, town, or county) (State): <i>Balto Md.</i>
DATE REC'D BY LOCAL REG: <i>April 12 53</i>	REGISTRAR'S SIGNATURE: <i>Dr. Kieffer</i>	24. FUNERAL DIRECTOR: <i>Howard H. Hubbard</i>	ADDRESS: <i>4107 Wilkens ave</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

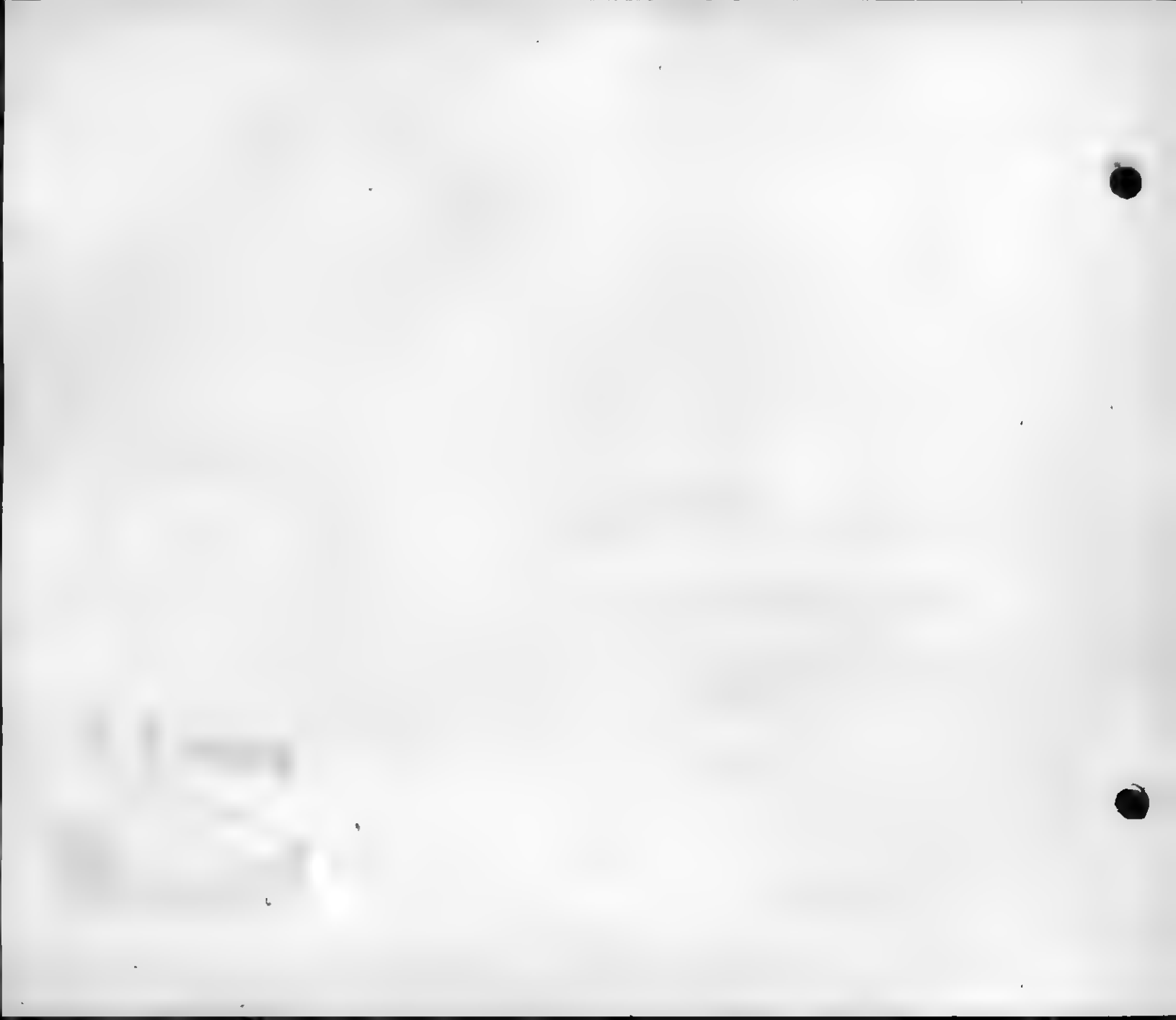


PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03444
3463 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL) <u>12 Catonsville</u> OR AT NEAREST TOWN TOWN <u>14 Spring Grove Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>1</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>11-2 Hyattsville</u> OR TOWN STREET ADDRESS (If rural, give location) <u>5714 Road St.</u>	
3. NAME OF DECEASED: (Type or Print) <u>ELIZABETH</u> (First) (Middle) (Last) <u>POWERS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>3</u> <u>1955</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>WIDOW</u>	8. DATE OF BIRTH: <u>Oct 10, 1863</u>
9. AGE last birthday <u>91</u> yrs		10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Cully</u>		14. MOTHER'S MAIDEN NAME: <u>Bridget Cullen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service):		16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS: <u>5714 Road St Cath. Mansfield Hyattsville, Maryland</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>45</u> IMMEDIATE CAUSE (A) <u>Senility</u> ANTECEDENT CAUSE (S) DUE TO <u>Generalized Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Cerebral Deterioration due to</u> (C) <u>(A) and (B).</u>		INTERVAL BETWEEN ONSET AND DEATH	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>8/12</u> , 19 <u>45</u> to <u>4/3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/3</u> , 19 <u>55</u> , and that death occurred at <u>1 P.</u> M. from the causes and on the date stated above. SIGNATURE <u>Spring Grove State Hospital.</u> ADDRESS <u>FEDERAL</u> DATE SIGNED <u>4/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-5/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/5/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
24. FUNERAL DIRECTOR <u>Nash's Funeral Home</u>		ADDRESS <u>3200 R. Lane Mt. Rainier, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

03445

3463

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. ... 47

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and OR the nearest town) TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> #6	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Best Steel Hse.</u>		STREET ADDRESS (If rural, give location) <u>9532 Belair Rd.</u>	
3. NAME OF DECEASED (First) <u>Maynard</u> (Middle) <u>Reckert</u> (Last) <u>Reckert</u>		4. DATE OF DEATH (Month) <u>Apr</u> (Day) <u>16</u> (Year) <u>595</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>9/18/1891</u>
9. AGE last birthday <u>63</u> yrs.		10. If under 1 year: Months <u>6</u> Days <u>3</u> Hours <u>59</u> Mins. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. Kind of BUSINESS OR OCCUPATION <u>Steel Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Andrew Reckert</u>		14. MOTHER'S MAIDEN NAME <u>Maria E. Gould</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mora Reckert 9532 Belair Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Coronary occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF DEATH Apr - 16 - 55 10 P.M.INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. METHOD, CREMATION

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-18-55

R W. [Signature]

W. Cook Inc 1217 St. Paul St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3465 MARYLAND. STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03446

CERTIFICATE OF DEATH

Reg. Dist. No. 27...

Item 12, Filmcl80 4-14-55 et

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND
CITY (If outside corporate limits, write RURAL, OR and give nearest town) **Parkville** LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS **2628 Wentworth Road #14**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Baltimore**
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Parkville**

STREET ADDRESS (If rural give location) **2628 Wentworth Road #14**

3. NAME OF DECEASED: (First) **Mr. Frederick (Fritz) Paul Reich** (Last)

4. DATE (Month) (Day) (Year) OF DEATH: **April 7th 1955**

5. SEX: **male** 6. COLOR OR RACE: **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **married** 8. DATE OF BIRTH: **Oct. 6, 1902**

9. AGE last birthday: **52** yrs. IF UNDER 1 YEAR: Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **Machinist** 10B. KIND OF BUSINESS OR INDUSTRY: **Koppers Co**

11. BIRTHPLACE (State or foreign country): **Germany** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME:

Mr. Julius Reich

14. MOTHER'S MAIDEN NAME:

Ida Kupser

15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

15. SOCIAL SECURITY NO.

212-07-5439

17. INFORMANT & ADDRESS:

Mrs. Elsie W. Reich, 2628 Wentworth Road

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

Due to

ANTECEDENT CAUSE (B)

Due to

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATE UNDERLYING CAUSE LAST

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Nov 15 1954**, to **Apr 8, 1955**, that I last saw the deceased alive on **Apr 7, 1955** and that death occurred at **3:00 P-M**, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

Apr. 11, 1955

NAME OF CEMETERY OR CREMATORY

Moreland Memorial Park

LOCATION (City, town, or county) (State)

Baltimore, Maryland

DATE REC'D BY LOCAL

April 9 1955

REGISTRAR'S SIGNATURE

R. W.

24. FUNERAL DIRECTOR

ADDRESS

Leonard J. Ruck 5305 Harford Road #14

Dr. Janney
7101 Harford Road
Friday 9 - 10 A.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

3358

03447

1. PLACE OF DEATH: COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto 22</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1840 North Pt Rd</u>		STREET ADDRESS (If rural, give location) <u>1840 North Pt Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth A</u>	(Middle) <u>Reinecke</u>	(Last) <u>Reinecke</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>19</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan 19-1972</u>
9. AGE last birthday <u>83</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Mary</u>		14. MOTHER'S MAIDEN NAME <u>Miss Gertrude Reinecke</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Gertrude Reinecke</u>		<u>1840 North Pt Rd</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Generalized Carcinomatosis</u>		<u>1 year</u>
Antecedent cause(s) (b) <u>Malignancy of left ovary</u>		<u>16 months</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Initial Stenosis & Regurgitation</u>		<u>10 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May, 1945, to Apr 19, 1955, that I last saw the deceased alive on Apr 19, 1955, and that death occurred at 10 P.m., from the causes and on the date stated above.

SIGNATURE Marie G. Gaudin (Degree or title) MD ADDRESS 1010 North Point Road DATE SIGNED 4/21/55

23. BURIAL, CREMATION (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4/22/55</u>	<u>Park Lawn CEM</u>	<u>Balto</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 27-1955</u>	<u>William M Kelly</u>	<u>William M Kelly</u>	<u>Funeral Home 7401 Balair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

3 'A OYUOL

581

3466

CERTIFICATE OF DEATH

03448

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROSEDALE		LENGTH OF STAY (in this place) APPROX. 50 YRS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROSEDALE		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7924 33rd ST.				STREET ADDRESS (If rural give location) 7924 33rd ST.		X	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
BERTHA M. REINHART				4 6 1955			
6. SEX: F	5. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 11/12/1885	9. AGE last birthday: 69 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): AT HOME				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.	
13. FATHER'S NAME: MILTON F. MORGAN				14. MOTHER'S MAIDEN NAME: IDA LOWE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: GEORGE S. REINHART 7924 33rd ST.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
422.1 Immediate cause (a) Arteriosclerotic Cardio-Vascular Disease			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral Sclerosis.			
(c)			

11. OTHER SIGNIFICANT CONDITIONS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **May 1951** to **April 6, 1955**, that I last saw the deceased alive on **April 5, 1955**, and that death occurred at **12:40 AM** from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	4/9/55	OAK LAWN	BALTO.	MD.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
4-7-55	AW Adams	C.F. Hoffmann	2219 LAKE ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



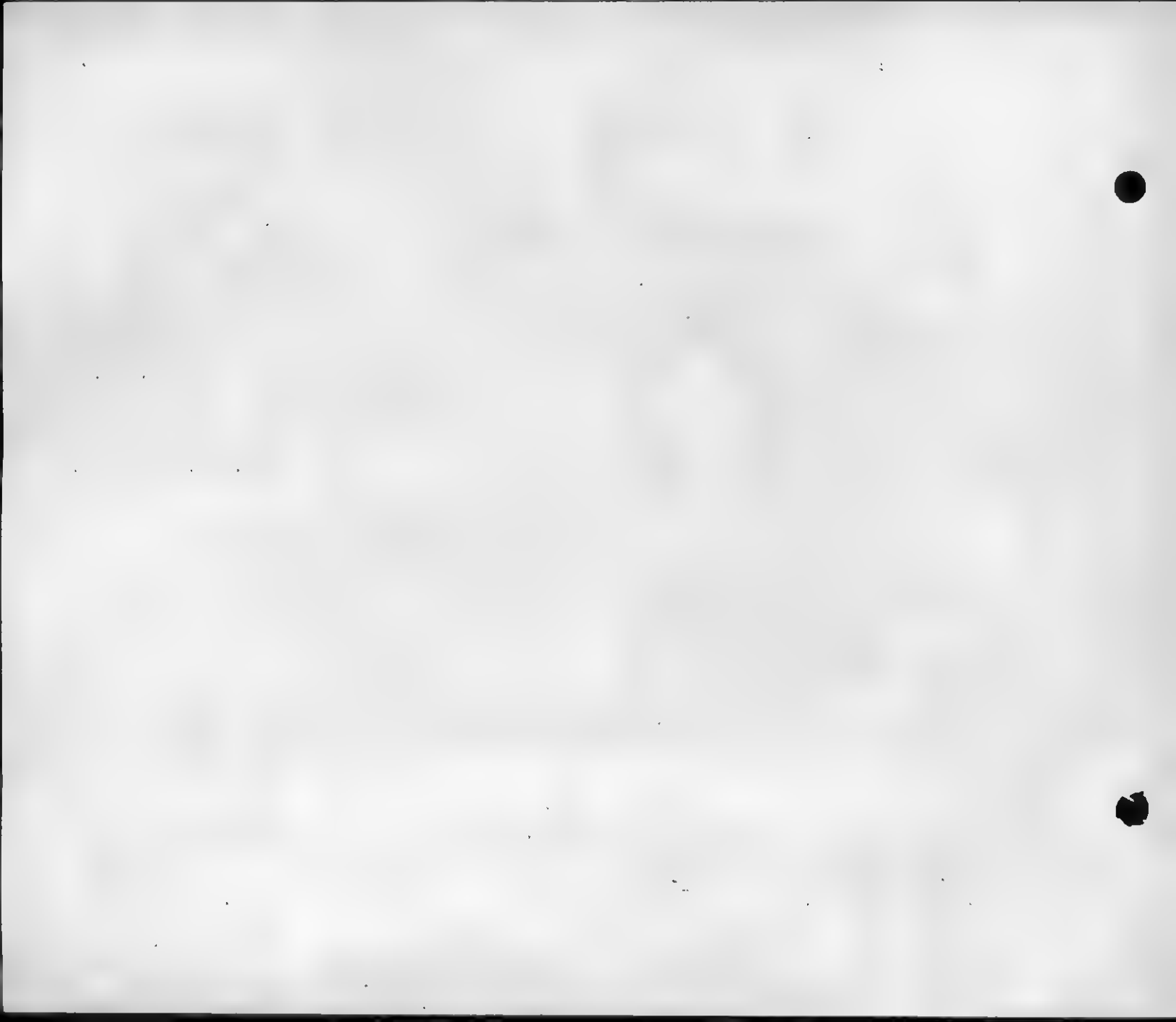
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03449

CERTIFICATE OF DEATH

Reg. Dist. No. *44*

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u> LENGTH OF STAY (in this place) <u>191 Days</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> STREET ADDRESS (If rural give location) <u>2767 West North Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>LEON A. RICHARDSON</u> SEX <u>Male</u> COLOR OR RACE <u>Colored</u> SINGLE, MARRIED, WIDOWED, OR DIVORCED (Specify) <u>Divorced</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>April 23, 1955</u> AGE last birthday IF UNDER 1 YEAR IF UNDER 24 MRS. Months Days Hours Min <u>58</u> yrs.	
5. SEX <u>Male</u>		8. DATE OF BIRTH: <u>5-27-96</u>	
10A. USUAL OCCUPATION: (Give kind of work done during most of working life even if retired) <u>Elevator Opr.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Factory</u>	
11. BIRTHPLACE: (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>EPHRAIM RICHARDSON</u>		14. MOTHER'S MAIDEN NAME: <u>ESTHER REISTER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW 1</u>		16. SOCIAL SECURITY NO. <u>216-07-7346</u>	
17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>150X</u> IMMEDIATE CAUSE (A) <u>CARCINOMA OF ESOPHAGUS WITH METASTASES</u> ANTECEDENT CAUSE (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>13 Months</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>10-25-54</u>		19B. MAJOR FINDINGS OF OPERATION <u>ESOPHAGOSCOPY-Finding of Carcinomatous tissue in Esophagus</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc. _____		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) _____	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY _____		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____		22. I hereby certify that <u>VA</u> attended the deceased from <u>Oct. 14, 1954</u> to <u>April 23, 1955</u> and that death occurred at <u>4:10 PM.</u> from the causes and on the date stated above.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
24. FUNERAL DIRECTOR <u>Arlington S. Phillips Funeral Home</u>		ADDRESS <u>1808 N. Monroe St. Baltimore, Maryland</u>	



3359

CERTIFICATE OF DEATH

Reg. Dist. No.

03450

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL, and give nearest town)			
TOWN <u>DUNDALK 22</u>		<u>18</u>		TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>110 VENTNOR TERRACE</u>				STREET ADDRESS (If rural give location) <u>110 VENTNOR TERRACE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>ROY SAMUEL RIDENOUR</u>				<u>4 13 1955</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED OCT. 13, 1919</u>		8. DATE OF BIRTH: <u>55</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>ROLLER HEWER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>STEEL MFR.</u>		11. BIRTHPLACE (State or foreign country): <u>KENNA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>CLARK RIDENOUR</u>				14. MOTHER'S MAIDEN NAME: <u>CORA HOOVER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u>		16. SOCIAL SECURITY No.: <u>213-07-4373</u>		17. INFORMANT & ADDRESS: <u>ANN H. RIDENOUR - SAME ADDRESS</u>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>3+ hrs.</u>	
331X Immediate cause (a) <u>Cerebral Accident</u>					
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>					
(c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Ca 13 lower Esophagus & Cardiac Portion of a tumor</u>					
19a. DATE OF OPERATION: <u>Aug 5, 1954</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Name as 11 - Pericard & Aorta - normal</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT (Specify) <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office, etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 1954</u> to <u>April 13, 1955</u> , that I last saw the deceased alive on <u>April 13, 1955</u> , and that death occurred at <u>330 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Wm. M. M.</u>		ADDRESS <u>Dundalk, Md.</u>		DATE SIGNED <u>4/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>4-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>	
LOCATION (City, town, or county) (State) <u>DORSEY, Md.</u>		24. FUNERAL DIRECTOR <u>William W. Kelle, 1100 North ...</u>		ADDRESS <u>Dundalk, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-14-55</u>		REGISTRAR'S SIGNATURE <u>William W. Kelle</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 15 1945

REC-100

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03451

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Batonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Hanover Dorsey</u> STREET ADDRESS (If rural give location) <u>RFD Forest Ave.</u>	
3. NAME OF DECEASED: (Type or Print) <u>William H. Riley</u>		4. DATE OF DEATH: <u>April 13, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH <u>12-23-1864</u>
9. AGE last birthday <u>90</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Storekeeper Employed</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Riley</u>		14. MOTHER'S MAIDEN NAME: <u>Sara A. Camron</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>491X</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		1 week	
(A) <u>Pulmonary abscesses and empyema</u> DUE TO			
(B) <u>Bronchopneumonia</u> DUE TO		weeks	
(C)			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic cardiovascular disease</u> Years			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-14-1955</u> , to <u>4-13-1955</u> that I last saw the deceased alive on <u>4-12-1955</u> , and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.			
SIGNATURE OF REGISTRAR <u>Louis Francis Woodward</u>		DATE SIGNED <u>4-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY <u>Greenwood Cemetery</u> LOCATION <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 16, 1955</u>		24. FUNERAL DIRECTOR <u>W. B. Singleton</u> ADDRESS <u>Elton Bunnies Rd.</u>	

E A OYER

1875-1876

3360

03452

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 4

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Dundalk</i>		LENGTH OF STAY (If in place) <i>22 yrs</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Dundalk</i>		<i>22 53</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>720 S. 51st.</i>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
<i>Ida (First) Rodgers (Last)</i>				<i>April 17 1955</i>			
5. SEX <i>Female</i>	6. COLOR OR HAIR <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widow</i>	8. DATE OF BIRTH: <i>Sept 17 1875</i>	9. AGE last birthday: <i>79</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Henry Schul.</i>				14. MOTHER'S MAIDEN NAME: <i>Minnie Sillinger.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs. Minnie Sillinger.</i>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause		(a) DUE TO		<i>Coronary occlusion -</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>	
Antecedent cause(s)		(b) DUE TO		<i>Card. Vas. Renal Disease.</i>		<i>over 15 yrs.</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF <i>April 4 17 1955 3p</i>		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>M. Carmine M.D.</i>		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>April 21/55</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel Cem.</i>		LOCATION (City, town or county) (State) <i>Balto. Md.</i>	
DATE REC'D BY LOCAL REG. <i>4-19-55</i>		REGISTRAR'S SIGNATURE <i>A.W. Pedersen</i>		FUNERAL DIRECTOR <i>John L. Miller</i>		ADDRESS <i>2334 Jefferson St.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3469

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X <u>Woodlawn</u>		<u>3 yrs.</u>		X <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7127 Southland Road.</u>				STREET ADDRESS (If rural, give location) <u>7127 Southland Road.</u>			
3. NAME OF DECEASED: (First) <u>BERNARD</u>		(Middle) <u>-</u>		(Last) <u>ROSE</u>		4. DATE OF DEATH: (Month) <u>Apr</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>Feb 18, 1871</u>	
9. AGE last birthday: <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Julius Rose</u>				14. MOTHER'S MAIDEN NAME: <u>Maria Saffray.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mildred R. De Ruha, 7127 Southland Rd. 7.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Coronary Occlusion, Acute</u>						Sudden	
DUE TO							
(b) Antecedent cause(s) <u>Generalized Arteriosclerosis</u>						unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
DUE TO							
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>20.1</u>				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June....., 1950., to April 7., 1955., that I last saw the deceased alive on Jan. 22., 1955., and that death occurred at 5 P.m., from the causes and on the date stated above.							
SIGNATURE <u>Dr. G. M. D.</u>				ADDRESS <u>1 Gallow Hill Ave.</u>		DATE SIGNED <u>4/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Apr 11, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 9, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>John F. Tufel</u>		ADDRESS <u>5311 Edmondson Ave.</u>	

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH

03454

3470

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Timonium</u>	
TOWN <u>Timonium</u> LENGTH OF STAY (In this place) <u>3 yrs.</u>		TOWN <u>Timonium</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>113 Northwood Drive</u>		STREET ADDRESS (If rural, give location) <u>113 Northwood Drive</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Russell</u> (Middle) <u>Harold</u> (Last) <u>Rosier</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>35</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 13, 1914</u>
9. AGE last birthday <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Emanuel Rosier</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Cummings</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES (Yes, no, or unknown) <u>Yes</u> (Month) <u>April</u> (Day) <u>41</u> (Year) <u>1946</u>		16. SOCIAL SECURITY No. <u>219-03-4239</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Dorothy Rosier, 113 Northwood Drive, Timonium, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 Immediate cause (a) <u>Heart disease, vascular, coronary occlusion</u>			
Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>William C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>4/25/55</u>	
23. BURIAL, CREMATION OR REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 28, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>New Freedom Cemetery</u>		LOCATION (City, town, or county) <u>New Freedom, York Co., Penna.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>April 26, 1955</u>		24. FUNERAL DIRECTOR <u>Isaac Sorkin</u>	
ADDRESS <u>New Freedom, Pa.</u>			

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No.

3471

I. PLACE OF DEATH:

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(Type or Print)

(First)

(Middle)

(Last)

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

491X Immediate cause

(a) ...

Bronchopneumonia

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...

DUE TO

(c)

Interval Between Onset And Death

3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

cerebral hemorrhage

90 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15, 1955, to 4-2, 1955, that I last saw the deceased

alive on 4-1, 1955, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

R.F.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03456

3472

CERTIFICATE OF DEATH

Reg. Dist. No.

80

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u> OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> OR TOWN STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) (Type or Print) <u>William</u> <u>Ryland</u> <u>Male</u> <u>White</u> <u>Single</u> <u>November 30, 1876</u>		OF DEATH: <u>APRIL 22</u> <u>1955</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>November 30, 1876</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
			<u>Maryland</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>? William Thomas Ryland</u>		<u>? Anne E. Mass</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:	
<u>Unk.</u>		<u>George Ryland, Pikesville, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE (S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertensive c.v. disease</u> DUE TO (C) <u>Generalized arteriosclerosis</u>			<u>years</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Aug. 15, 1919, to April 22, 1955, that I last saw the deceased alive on April 22, 1955, and that death occurred at 1:40 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<u>Spring Grove State Hospital, Catonsville, Maryland, U. R. Cowen, M.D.</u>		<u>April 22, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>April 25, 1955</u>	<u>David Ridge</u>	<u>Pikesville</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/27/55</u>	<u>Victor Harry</u>	<u>Frank H. Powell</u>	<u>Pikesville</u>

BUREAU V. S.

APR

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03457

3473

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 6 HOURS	CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL	STREET ADDRESS (If rural give location) 815 N. Calvert Street		
3. NAME OF DECEASED: (First) (Middle) (Last) GEORGE SAHERSHUK		4. DATE (Month) (Day) (Year) OF DEATH APRIL 15 1955	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: SEPTEMBER 6, 1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SOLDIER		10B. KIND OF BUSINESS OR INDUSTRY: RETIRED	9. AGE last birthday IF UNDER 1 YEAR Months Days Hours Min. 56
11. BIRTHPLACE (State or foreign country): KOWEL, POLAND		12. CITIZEN OF WHAT COUNTRY: U. S. A.	
13. FATHER'S NAME: WASH SAHERSHUK		14. MOTHER'S MAIDEN NAME: IRENE KOBETZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If Yes, give year or dates of service) YES WW-II		16. SOCIAL SECURITY NO.: 213-28-0114	
17. INFORMANT & ADDRESS: CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
IMMEDIATE CAUSE (A) MICROCYTIC ANEMIA			
ANTECEDENT CAUSE (B) UNKNOWN			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? 12:45 PM 6:45 PM			
22. I hereby certify that I attended the deceased from APR. 15, 1955 , to APR. 15, 1955 , that I saw the deceased and that death occurred at 6:45 PM , from the causes and on the date stated above.			
SIGNATURE WILLIAM B. VANDEGRIFT, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 4-16-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 4-16-1955		NAME OF CEMETERY OR CREMATORY WOODLAWN CEMETERY	
LOCATION (City, town, or county) (State) BLUEFIELD, WEST VIRGINIA			
DATE OF BURIAL APR 16 1955		REGISTRAR'S SIGNATURE Wm. Cook-Blight, Inc. Funeral Home	
FUNERAL DIRECTOR 6009 Harford Rd., Balto., Md.			
SHIPPED TO: Northfork Funeral Home, Northfork, W. Va.			

A. 000000

3474

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u> OR TOWN <u>PIKESVILLE</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Church Lane</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PIKESVILLE</u> STREET ADDRESS (If rural give location) <u>5 Church Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES COREY SALTER</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>APRIL 16 1955</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Aug. 27 1880</u>
9. AGE last birthday <u>74</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired</u>		12. BIRTHPLACE (State or foreign country): <u>BALTIMORE CITY Md</u>	
13. FATHER'S NAME: <u>WILLIAM HENRY SALTER</u>		14. MOTHER'S MAIDEN NAME: <u>ALICE CORCY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unk.): <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-143208A</u>	
17. INFORMANT & ADDRESS: <u>SAME ADDRESS</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>		2 mos.	
ANTECEDENT CAUSE (B) <u>Art. Sclerosis</u>		2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension</u>		2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify, that I attended the deceased from <u>May 1953</u> to <u>April 16, 1955</u> , that I last saw the deceased alive on <u>April 16, 1955</u> , and that death occurred at <u>5:05 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>James G. Miller M.D.</u>		DATE SIGNED <u>4/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>April 19, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mount Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 18, 1955</u>		REGISTRAR'S SIGNATURE <u>Maathya A. Newell</u>	
24. FUNERAL DIRECTOR <u>FRANK H. Newell</u>		ADDRESS <u>Pikesville Md</u>	

MARGIN RESERVED FOR BINDING

RECEIVED
APR 22 1955
MILITARY

CERTIFICATE OF DEATH

Reg. Dist. No. 42

3475

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL or give nearest town) OR TOWN <u>Lansdowne</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 Elizabeth Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lansdowne</u> STREET ADDRESS (If rural give location) <u>102 Elizabeth Ave.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EDWARD</u> (Middle) <u>GEORGE</u> (Last) <u>SCHEMINANT</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>Apr.</u> <u>23</u> , 19 <u>55</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 7, 1880</u>
9. AGE last birthday: <u>74</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Plumbing</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Charles B. Scheminant</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Crone</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO: <u>412-07-2467</u>	
17. INFORMANT & ADDRESS: <u>Mr. Earl B. Scheminant-35 Elizabeth Ave.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>443X</u>		<u>6 yrs</u>	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>12 yrs?</u>	
(A) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
(B) <u>ESSENTIAL HYPERTENSION</u>			
(C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>CEREBRAL HEMORRHAGE</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JUNE 7, 1947</u> , to <u>APRIL 23, 1955</u> , that I last saw the deceased alive on <u>APRIL 20, 1955</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>C. Patton Rossberg</u>		ADDRESS <u>M. D. 3436 Washington Blvd</u>	
DATE SIGNED <u>4/26/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/27/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-26-55</u>		REGISTRAR'S SIGNATURE <u>W. H. Hedrick</u>	
FUNERAL DIRECTOR <u>Wm. J. Vickers & Sons - Balto.</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING



03460

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3366

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH- COUNTY <u>Balto.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5544 Selma Ave</u>		STREET ADDRESS (If rural, give location) <u>5544 Selma Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Mary Etta Schlickenmaier</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 22 1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>April 9, 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis E. Jackson</u>	
14. MOTHER'S MAIDEN NAME <u>Ida N. Ireland</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY No.		17. INFORMANT <u>Doris Hutchens - 5544 Selma Ave</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

UREMIA

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

DIABETES MELLITUS

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from JAN, 1941, to APRIL, 1955, that I last saw the deceased alive on 22 APRIL, 1955, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 25, 1955</u>	<u>Louisa Park Cem.</u>	<u>Balto.</u>	<u>md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>April 25, 1955</u>	<u>Geo. Kieffer</u>	<u>John T. Stansbury</u>	<u>6411 Windsor Mill Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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03461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3476

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Notch Cliff near Towson</u> X	
TOWN <u>Notch Cliff near Towson</u>		TOWN <u>Notch Cliff near Towson</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria</u>		STREET ADDRESS <u>Penarm Rd.</u> 1	
3. NAME OF DECEASED (Type or Print) <u>Sister Mary Theresia Schmitt</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>18</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Aug 2 1869</u>
9. AGE last birthday <u>85</u> yrs.		10. AGE last birthday If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Philip J. Schmitt</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Tittlbach</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Sr. Mary Clara Notch Cliff Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4. Immediate cause (a) Coronary Thrombosis Sudden

Antecedent cause(s) (b) Arterio sclerotic cardiac renal vascular disease 15 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from April, 1952., to April, 1955., that I last saw the deceased alive on March 8, 1955., and that death occurred at 9:15 A. m., from the causes and on the date stated above.

SIGNATURE Charles E. Donald Md. ADDRESS VILLA MARIA CEM. NOTCH CLIFF DATE SIGNED NR (State)

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>4-20-55</u>	NAME OF CEMETERY OR CREMATORY <u>OLD LAWN CEM. TOWSON</u>	LOCATION (City, town, or county) <u>NR (State)</u>
DATE REC'D BY LOCAL REG. <u>4-20-55</u>	REGISTRAR'S SIGNATURE <u>V. F.</u>	24. FUNERAL DIRECTOR, ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>	

MARGIN RESERVED FOR BINDER

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100-1000



100-1000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03462

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> TOWN <u>52</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hosp.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Fullerton</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN <u>1</u> STREET ADDRESS (If rural give location) <u>748 Belair Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Margaret Segrist (diagnos)</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>4</u> <u>12</u> <u>1955</u>	
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH: <u>74</u> ? yrs Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NOISE</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A</u>	
13. FATHER'S NAME: <u>Jacob ? Segrist</u>		14. MOTHER'S MAIDEN NAME: <u>Mary ? B.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.): <u>No</u> If Yes, give war or dates of service: <u>—</u>		16. SOCIAL SECURITY NO.: <u>?</u>	
17. INFORMANT'S ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE: <u>172X</u> ANTECEDENT CAUSE (S): <u>Carcinoma Rt. breast with metastases</u>			<u>3 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>1955</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Rt. mastectomy, w/ carcinoma</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 1931</u> , to <u>April 12, 1955</u> , that I last saw the deceased alive on <u>April 12, 1955</u> , and that death occurred at <u>8:50 P.M.</u> from the causes and on the date stated above.			
SIGNATURE: <u>Charles W. Ward</u>		ADDRESS: <u>Spring Grove Hosp.</u> DATE SIGNED: <u>4/12/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>BURIAL</u>		DATE THEREOF: <u>4-16-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State): <u>Fullerton Md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>Apr 15, 1955</u>		REGISTRAR'S SIGNATURE: <u>H. U. Hedrick</u>	
24. FUNERAL DIRECTOR: <u>Gerard J. Kuck</u>		ADDRESS: <u>305 N. 1st</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3367

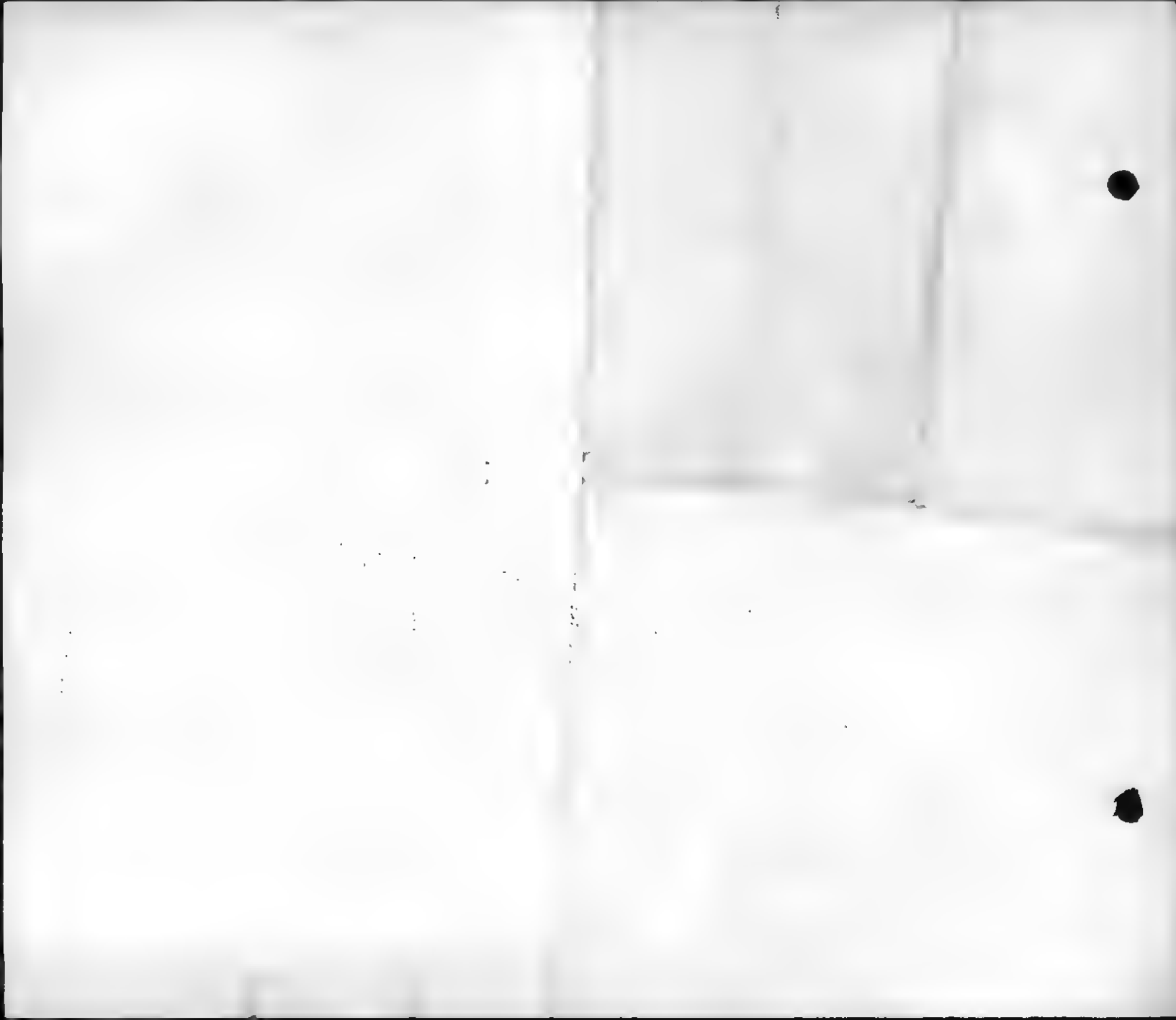
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)		X			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>DIANE CAROL SILVER</u>				OF DEATH: <u>4</u> - <u>5</u> - <u>1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH:	9. AGE last birthday: yrs	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md</u>	
13. FATHER'S NAME: <u>Nathan Silver</u>				14. MOTHER'S MAIDEN NAME: <u>Lillian Rock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT & ADDRESS: <u>Nathan Silver -</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Septic & pneumonia</u>				<u>8-12 hrs</u>			
ANTECEDENT CAUSE (B) <u>URI</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Prematurity</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 13, 1955</u> , to <u>Apr. 5, 1955</u> , that I last saw the deceased alive on <u>Apr. 2, 1955</u> , and that death occurred at <u>4:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert J. Jones</u>		ADDRESS <u>4115 W. Roper Ave</u>		DATE SIGNED <u>4-5-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-5-55</u>		<u>Rosedale</u>		<u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4-5-55</u>		<u>G. W. DeLoach</u>		<u>Jack Lewis</u>		<u>2100 Eutaw Pl</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Apply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

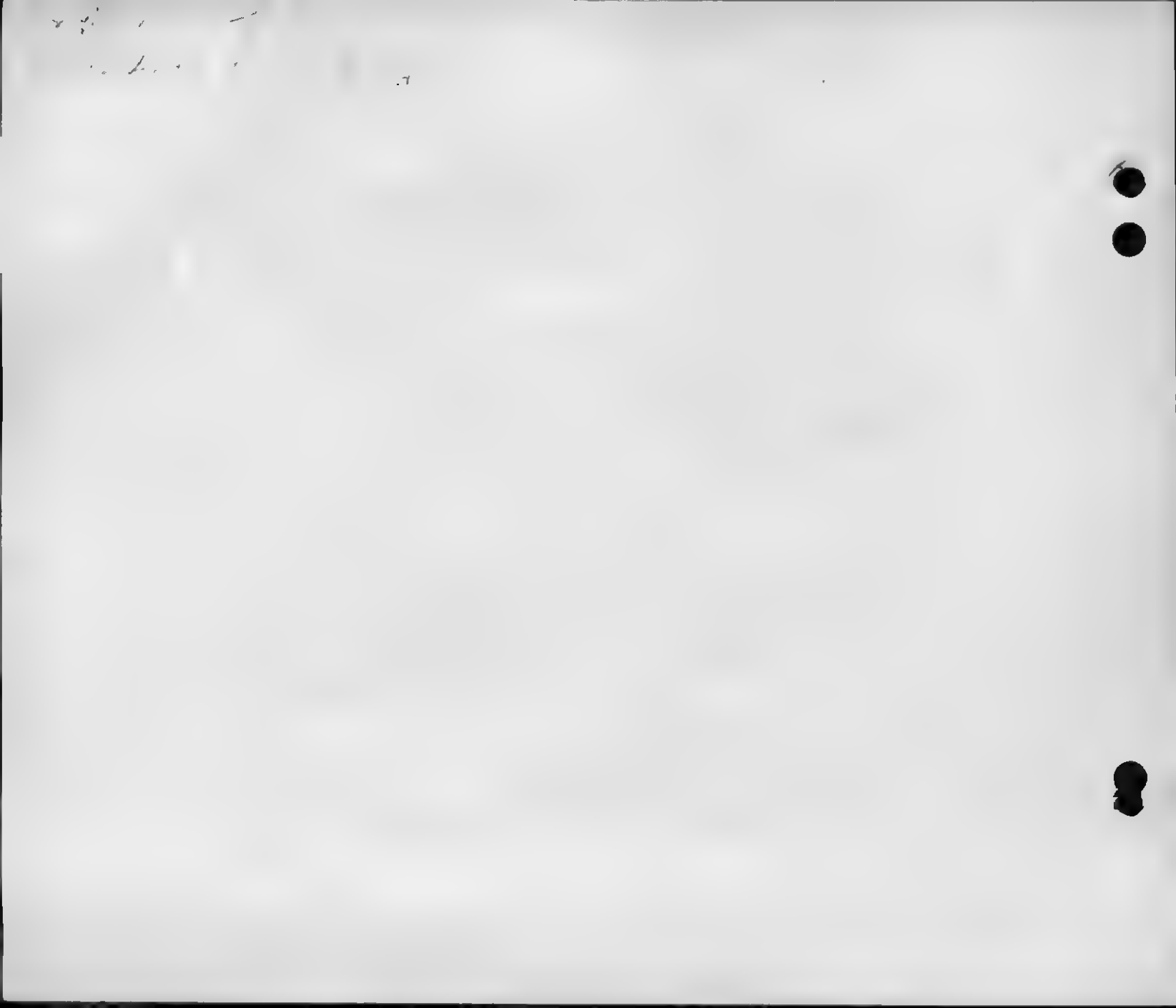
2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

03464

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baynesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#79 Compens Rd</u>		STREET ADDRESS (If rural, give location) <u>#79 Compens Rd R.F.D. 6</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna C Sims</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>12</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>April 24-1901</u>
9. AGE last birthday <u>53</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Traband</u>		14. MOTHER'S MAIDEN NAME <u>Clara Engle</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr Herbert J. Sims #79 Compens Rd</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X Immediate cause</u> (a) <u>Carcinoma of pancreas</u> <u>Antecedent cause(s)</u> (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5.2.55</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/15</u> , 19 <u>55</u> , to <u>4/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/12</u> , 19 <u>55</u> , and that death occurred at <u>5:15 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>John H. Sims</u>		ADDRESS <u>8523 Fork River Rd</u>	
DATE SIGNED <u>4/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4/15/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Morland Hill Park</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
24. FUNERAL DIRECTOR <u>Lanshaw Funeral Home</u>		ADDRESS <u>7401 Balin Rd</u>	
DATE REC'D BY LOCAL REG. <u>4-13-55</u>		REGISTRAR'S SIGNATURE <u>GTE</u>	



3479 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

03465

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> OR TOWN <u>Pikesville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>24 WALDRON AVE</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTIMORE</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> OR TOWN <u>Pikesville</u> STREET ADDRESS (If rural give location) <u>24 WALDRON AVENUE</u>	
3. NAME OF DECEASED: (Type or Print) <u>ROBERT SLEERT</u>		4. D E (Month) (Day) (Year) OF DEATH <u>APR 11</u> <u>6</u> <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MAR (IED) WIDOWED DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH: <u>JULY 11, 1891</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKBINDER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>BOOKBINDER</u>	
11. BIRTHPLACE (State or foreign country): <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Michael Sleert</u>		14. MOTHER'S MAIDEN NAME: <u>Sophia Brehm</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>216-05-1067</u>	
17. INFORMANT & ADDRESS: <u>MARY C SLEERT</u>		SAME address	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 IMMEDIATE CAUSE	(A) <u>Coronary Thrombosis</u>	<u>12 hrs.</u>
ANTECEDENT CAUSE (B)	<u>Coronary Sclerosis</u>	<u>1 yr.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST	(C) <u>Art. Sclerosis</u>	<u>2 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1954 to April 6, 1955, that I last saw the deceased alive on April 6, 1955, and that death occurred at 6:55 A.M. from the causes and on the date stated above.

SIGNATURE <u>James A. Mille</u>	DATE SIGNED <u>April 11, 1955</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>APRIL 9, 1955</u>
NAME OF CEMETERY OR CREMATORY <u>DROID RIDGE</u>	LOCATION (City, town, or county) (State) <u>Pikesville MD</u>
DATE REC'D BY LOCAL REGISTRAR <u>APR 11 8, 1955</u>	REGISTRAR'S SIGNATURE <u>Lois A. Mille</u>
24. FUNERAL DIRECTOR <u>FRANK H NEWELL</u>	ADDRESS <u>Pikesville MD</u>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FORWARD M. S.

APR 13 1950

03466

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3480

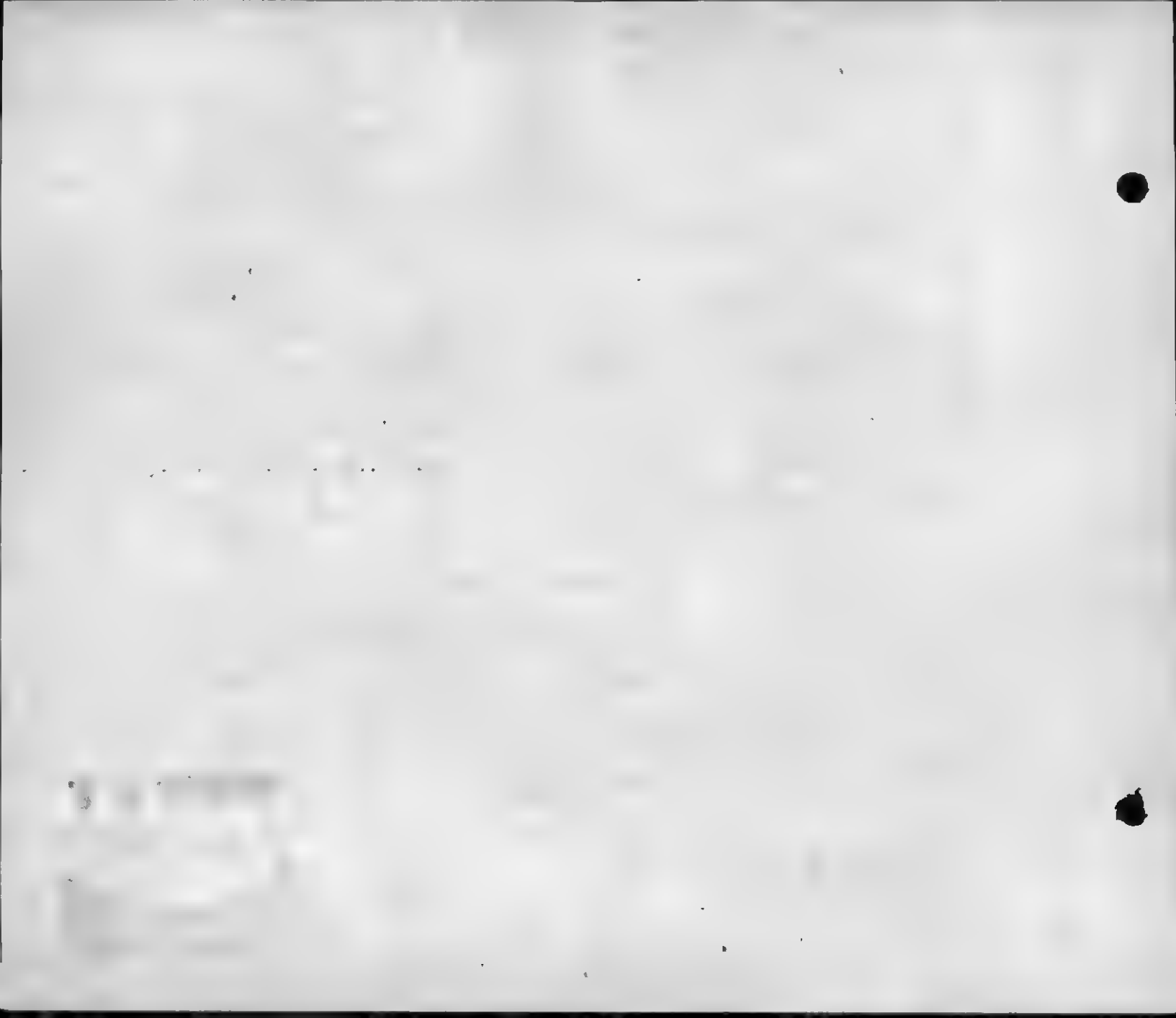
CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR INDEXING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Fort Howard</u>		<u>17 days</u>		TOWN <u>Centreville, M</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Box 571</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		5. SEX:		6. COLOR OR RACE:	
WILTON D. SPARKS		April 3 1955		Male		White	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>2/9/93</u>		9. AGE last birthday: <u>62</u> yrs.		10. MONTHS: <u>3</u> Days: <u>1</u> Hours: <u>15</u> Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <u>Machanist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Manufacturing</u>		11. BIRTHPLACE (State or foreign country): <u>Centreville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William S. Sparks</u>				14. MOTHER'S MAIDEN NAME: <u>Mary W. Dulin</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>214-12-9321</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>				18. MEDICAL CERTIFICATION			
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
470.0 IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION				3 WEEKS			
ANTECEDENT CAUSE (B) CORONARY THROMBOSIS							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ARTERIOSCLEROTIC HEART DISEASE							
19. DATE OF OPERATION:				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 17, 1955, to April 3, 1955, that I saw the deceased on April 3, 1955, and that death occurred at 12:01 AM, from the causes and on the date stated above.							
SIGNATURE <u>Abraham Polachuk, M.D.</u>				DATE SIGNED <u>4/3/55</u>			
ABRAHAM POLACHEK, M. D.				M. D. VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cemetery</u>			
DATE REC'D BY LOCAL REGISTRAR <u>April 5 1955</u>				LOCATION (City, town, or county) (State) <u>Centreville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Barton Brothers Funeral Home</u>				ADDRESS <u>Centreville, Maryland</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

03467

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

3481

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Randallstown</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Offutt Road</u>		STREET ADDRESS (If rural, give location) <u>Offutt Road</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>GEORGE</u> (Middle) <u>EDWARD</u> (Last) <u>SPEALMAN</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>APR. 4th.</u> 19 <u>55</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug. 31, 1877</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired -- Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self House Painter</u>	9. AGE last birthday <u>77 Years</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Spealman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wesekeer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Edward W. Spealman Offutt Road</u> <u>Randallstown, Maryland</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Immediate cause <u>157 X (a) Carcinoma of Pancreas</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Pancreas</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 1954, 19....., to 4/4/, 1955, that I last saw the deceased alive on 4/4/, 1955, and that death occurred at 10.40 P.m., from the causes and on the date stated above.

SIGNATURE Wm. E. Martin, M.D. ADDRESS Randallstown Md DATE SIGNED 4/5/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April, 7, 1955</u>	<u>Mt. Olive Cemetery</u>	<u>Randallstown, Balto Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/5/55</u>		REGISTRAR'S SIGNATURE <u>Wm. E. Martin</u>		
		FUNERAL DIRECTOR <u>Wm. E. Martin</u> ADDRESS <u>4510 Liberty Heights Ave.</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

22

22

22

MARYLAND STATE DEPARTMENT OF HEALTH

03468

3482

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Items 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Gray Manor</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>7632 Spruce Road</u>	
3. NAME OF DECEASED (Type or Print) <u>John Stachlinski</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>26</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>1876</u> <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Stachlinski</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Cindy Stachlinski Son</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002</u> Immediate cause (a) <u>Acute Pneumonitis</u> Antecedent cause(s) (b) <u>Pulmonary Tuberculosis</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arterio-Sclerosis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>10 years</u> <u>2</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work Not While At work
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from January 1955, to Apr 26, 1955, that I last saw the deceased alive on Apr 26, 1955, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

SIGNATURE Morris A. Jacob (Degree or title) MD ADDRESS 1010 NORTH Point Rd Balto 24. Md. DATE SIGNED 4/27/55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Buried</u>	<u>April 29/55</u>	<u>St Stanislaus</u>	<u>Baltimore</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4-27-55</u>	<u>Wm. A. Jacob</u>	<u>Fred W. Ozasowski</u>	<u>1930 Eastern Ave</u>

MARGIN RESERVED FOR PRINTING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3483 CERTIFICATE OF DEATH

03469

Reg. Dist. No. 41

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Gray Manor
OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2600 McComas Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) Gray Manor
OR TOWN
STREET ADDRESS (If rural give location) 2600 McComas Ave

3. NAME OF DECEASED:

(First) Mary (Middle) Ann (Last) Stanfield

4. DATE OF DEATH: April 14 1955 (Month) (Day) (Year)

5. SEX:

6. COLOR OR RACE: Female white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow

8. DATE OF BIRTH:

Sept 22 1882

9. AGE last birthday: 72 yrs. If UNDER 1 YEAR: Months: Days: Hours: Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Don't know

14. MOTHER'S MAIDEN NAME:

Don't know

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Nannie Lou Stanfield 2600 McComas Ave

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause

(a) DUE TO

Cerebral Hemorrhage

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

Diabetes Mellitus

(c)

Hypertension

Interval Between Onset And Death
10 hours
2 (6 mo)
8 years

11 OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb, 1955, to Apr 14, 1955, that I last saw the deceased alive on Apr 14, 1955, and that death occurred at 10:30 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 15-1955 William M. Kelly

Ullrich Funeral Home 2112 Dundalk Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. E.

1955

1955

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3484 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

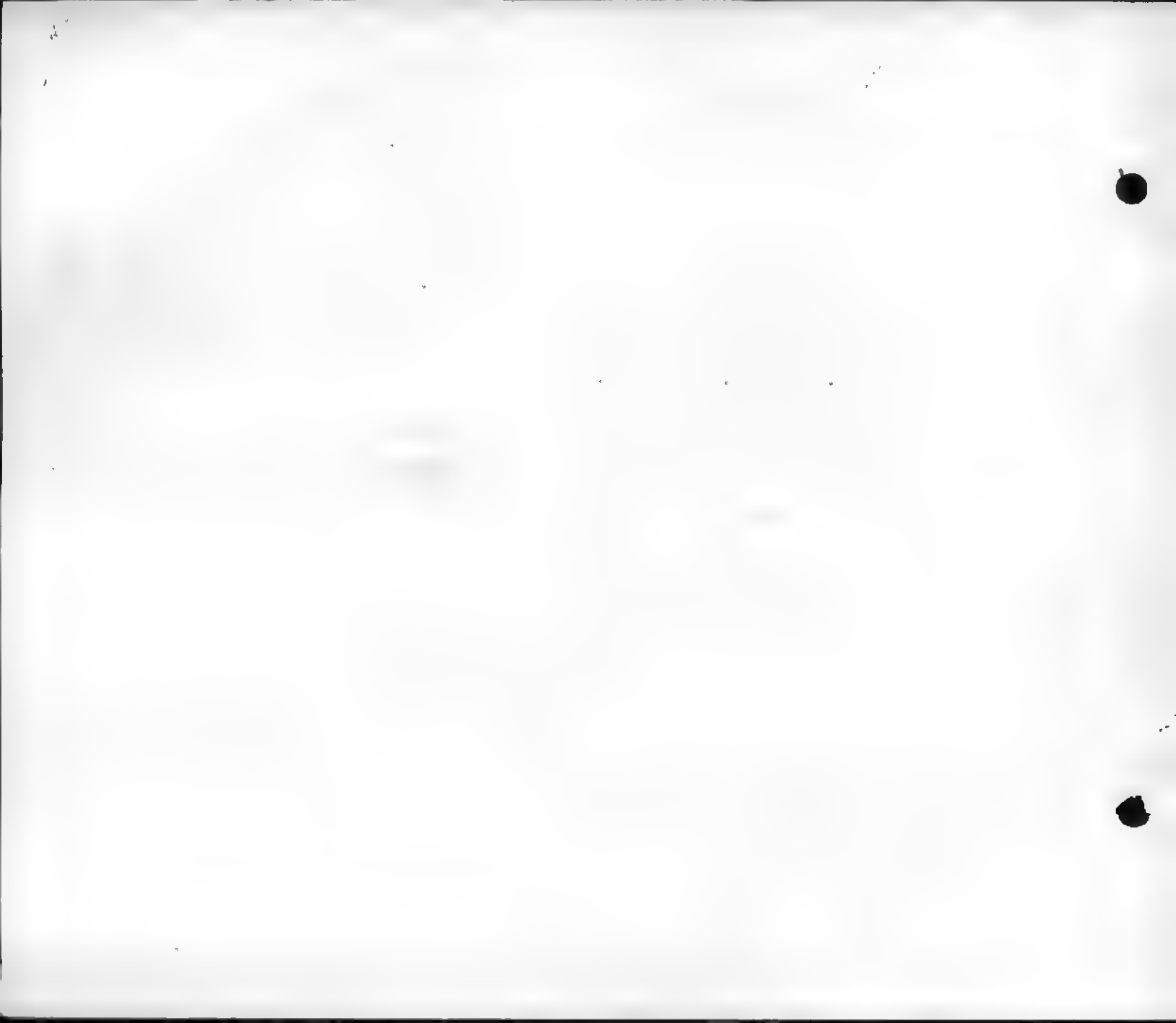
03470

43

Item 4 Funeral director's error: L 4-11-55
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Overlea	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 McCormick Ave.		STREET ADDRESS (If rural give location) 3026 Guilford Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) ALFRED GALT STARR, Sr.		4. DATE (Month) (Day) (Year) OF DEATH: April 11, 1955	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Jan. 16, 1878
9. AGE last birthday: 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Constr.	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME: Milton S. Starr	
14. MOTHER'S MAIDEN NAME: Catherine E. Longley		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: 212-10-0636		17. INFORMANT & ADDRESS: Mr. Alfred G. Starr Sr. 3026 Guilford Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Occlusion			Sudden
ANTECEDENT CAUSE (B) Hypertension Arteriosclerotic Cardiovascular Disease			7 yrs
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 2 Angina Pectoris			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 17, 1955 , to Apr 2, 1955 , that I last saw the deceased alive on March 17, 1955 , and that death occurred at AM , from the causes and on the date stated above.			
SIGNATURE J. Frank Dunlap, III (Son Dr Robert Garis)		DATE SIGNED 4/11/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/5/55	
NAME OF CEMETERY OR CREMATION Methodist Cem.		LOCATION (City, town, or county) (State) Uniontown, Md.	
DATE REC'D BY LOCAL REGISTRAR 4-4-55		REGISTRAR'S SIGNATURE R. W. [Signature]	
FUNERAL DIRECTOR Wm. F. [Signature]		ADDRESS Sons. Balto Md	



3485 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

03471

30

1. PLACE OF DEATH.

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Catonsville 28 LENGTH OF STAY (in this place)
1yr7mos5da
 HOSPITAL OR INSTITUTION OR STREET ADDRESS
14 Spring Grove State Hosp.

2 USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Baltimore 17
 STREET ADDRESS (If rural give location)
1608 Eutaw Place

3. NAME OF DECEASED:

(First) (Middle) (Last)
 (Type or Print) Arthur George Stedman

4. DATE (Month) (Day) (Year)
 OF DEATH April 13 19 55

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
Married

8. DATE OF BIRTH:

3/15/1890

9. AGE last birthday:

65 yrs

IF UNDER 1 YEAR Months Days Hours Mln.
 IF UNDER 24 HRS.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):
Michigan

12. CITIZEN OF WHAT COUNTRY?
USA

13. FATHER'S NAME:

Frank Stedman

14. MOTHER'S MAIDEN NAME
Ida May White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:
Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE

(A) Arteriosclerotic cardiovascular disease Years

ANTECEDENT CAUSE (S)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION. 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
 YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)
 INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY
 M

21E. INJURY OCCURRED While ☐ Not while ☐
 at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-23-, 1953, to 4-13-, 1955 that I last saw the deceased alive on 4-12-, 1955, and that death occurred at 8:45 AM, from the causes and on the date stated above.

SIGNATURE

Loraine Frances Woodward

ADDRESS Spring Grove State Hospital DATE SIGNED 4-13-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

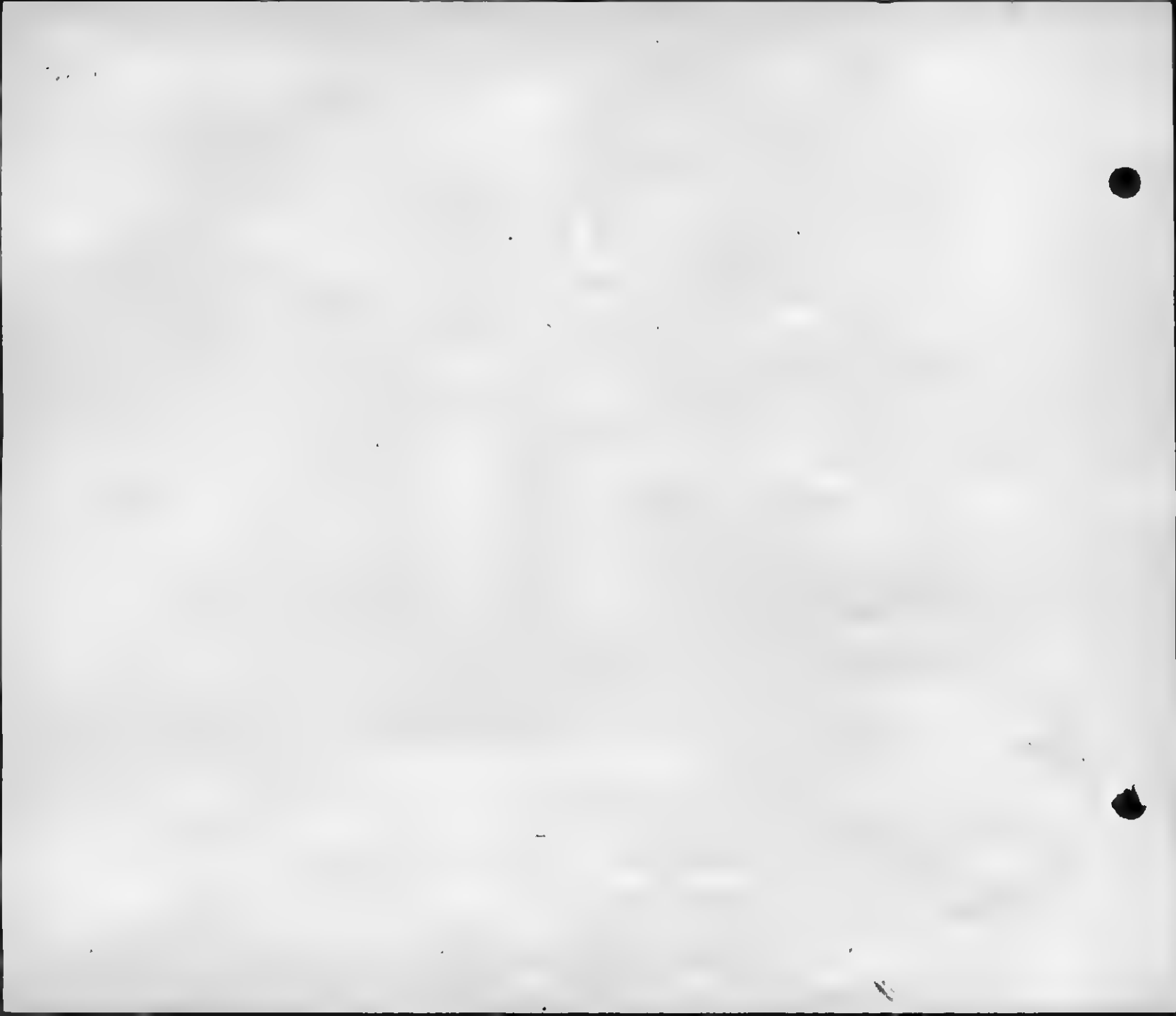
ADDRESS

4-13-55 H.W. Weddell Q. Mitchell 1600 Eutaw Place

MARGIN RESERVED FOR BINDING

VS. A15—10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3486

CERTIFICATE OF DEATH

Reg. Dist. No. 03472

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>52</u> <u>TOWN Catonsville</u> <u>28</u>		<u>18 yrs.</u>		<u>Catonsville 28</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
<u>24 Wyndcrest Avenue</u>				<u>24 Wyndcrest Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>BESSIE K. STOKES</u>				<u>April 28, 1955.</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE MARRIED. WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 Hrs.	
<u>Female</u>	<u>white</u>	<u>Married</u>	<u>December 25, 1874</u>	<u>80</u> yrs	<u>Months</u>	<u>Days</u>	<u>Hours</u> <u>Min.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>John F. Arthur</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		15. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Mr. Harry F. Stokes, Catonsville 28, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arteriosclerotic cardiovascular disease</u>						<u>5 yrs +</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertrophic + Rheumatoid arthritis</u>						<u>5 yrs +</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1952</u> , 19...., to <u>April 25, 1955</u> ; that I last saw the deceased alive on <u>April 27, 1955</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Johna Herbst, Jr.</u>		<u>M.D. 1115 St. Paul St. Balt. 2 Md.</u>		<u>4-29-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Apr. 30, 1955</u>		<u>Loudon Park Cemetery</u>		<u>Baltimore, Maryland.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>4/29/55</u>		<u>T.E. Harris</u>		<u>Easton Sons, Catonsville 28, Md.</u>			

9-12-1944

10-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

03473

3487

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE New York COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) Timonium				CITY (If outside corporate limits, write RURAL and give nearest town) Yonkers			
TOWN Timonium				TOWN Yonkers			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Timonium Fair Grounds				STREET ADDRESS (If rural, give location) 29 Holly Street			
3. NAME OF DECEASED (Type or Print)		(First) LYDIA		(Middle) MYERS		(Last) STREHLAU	
5. SEX FEMALE		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married		4. DATE OF DEATH (Month) April (Day) 24 (Year) 1955	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY American Bk Sta. Co.		8. DATE OF BIRTH July 1, 1904	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs Hours Min.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME William H. Myers			
14. MOTHER'S MAIDEN NAME Lydia M. Murphy				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY No.				17. INFORMANT AND ADDRESS 29 Holly Street Robert B. Strehlau, Yonkers, New York			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
(a) 420.1 Immediate cause Heart disease, coronary occlusion						Sudden	
(b) Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last Coronary disease with thrombosis						10 yrs.	
(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>							
SIGNATURE Rollin L. Hudson M.D., D.M.E.				DATE SIGNED 4/24/55			
23. BURIAL, CREMATION OR REMOVAL (Specify) Burial				DATE THEREOF 4/27/55			
NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				LOCATION (City, town, or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Wm. Cook & Co.				ADDRESS 1217 St. Paul Street			



CERTIFICATE OF DEATH

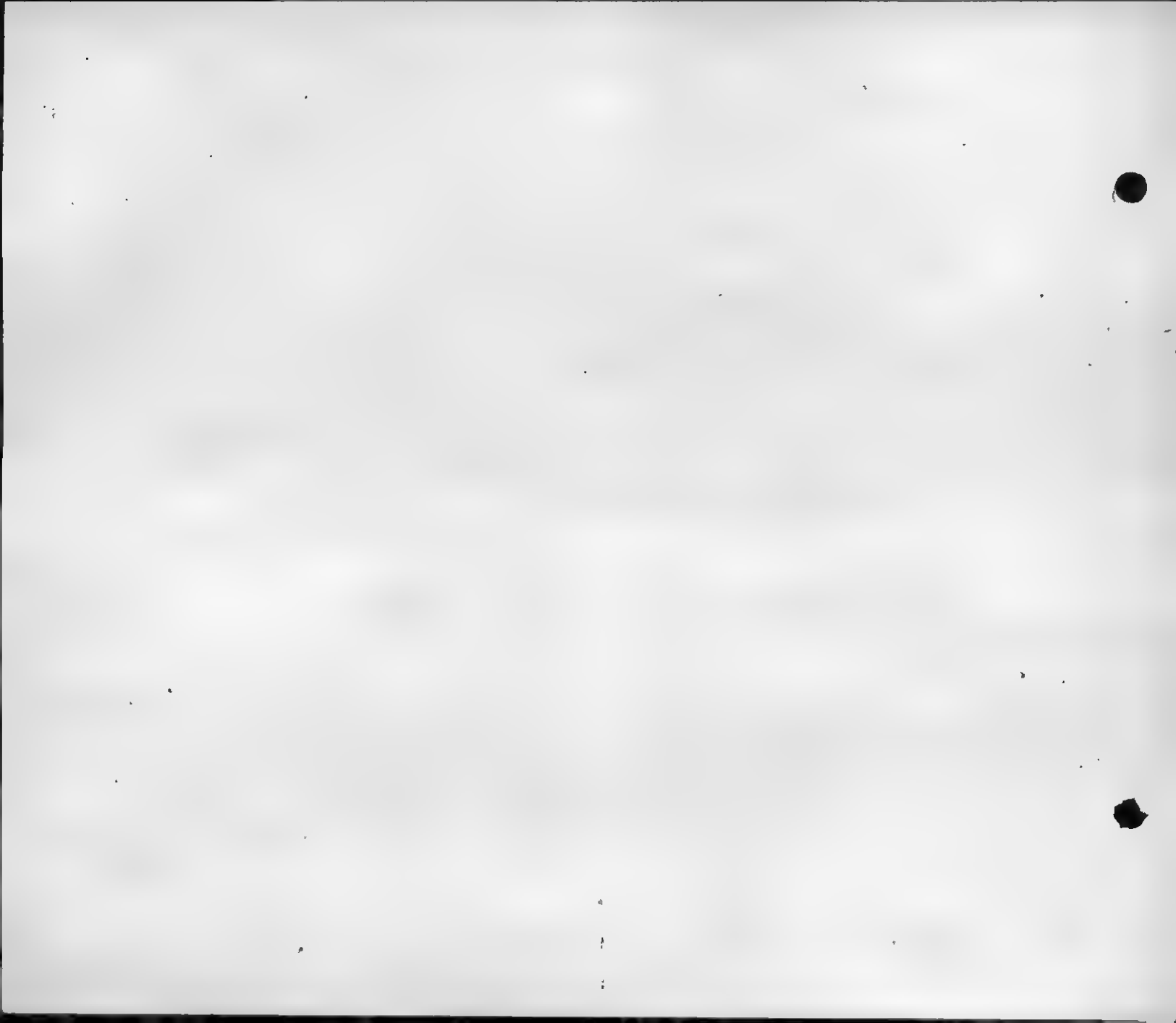
Reg. Dist. No. 42

3368

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Arbutus</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1031 Beechfield Ave.</u>		STREET ADDRESS (If rural give location) <u>1031 Beechfield Ave.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Charles E. Strupp</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 17 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>MARRIED</u>	8. DATE OF BIRTH: <u>May 3rd 1897</u>
9. AGE last birthday <u>57</u> yrs.		10. MONTHS <u>5</u> DAYS <u>17</u> HOURS <u>15</u> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Plumber</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>John Burgonn</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Henry Strupp</u>		14. MOTHER'S MAIDEN NAME: <u>Louise (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>215-03-6645</u>	
17. INFORMANT & ADDRESS: <u>Grace Strupp Arbutus</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>3 weeks</u>
ANTECEDENT CAUSE (B) <u>Original Syndrome</u>			<u>?</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 30, 1955</u> , to <u>April 17, 1955</u> , that I last saw the deceased alive on <u>April 16, 1955</u> , and that death occurred at <u>4:30A M.</u> from the causes and on the date stated above.			
SIGNATURE <u>John T. Coolahan</u>		DATE SIGNED <u>4/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/21/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>4-19-55</u>		REGISTRAR'S SIGNATURE <u>Wm. Fredrick</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook Inc. 1217 St. Paul St.</u>		ADDRESS	

MARON RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 03475

3488

1 PLACE OF DEATH

COUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Stoneloigh

HOSPITAL OR INSTITUTION OR

STREET ADDRESS 907 Old Oak Rd.

MARYLAND

LENGTH OF STAY (in this place)

2 USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Balto.

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Stoneloigh

STREET ADDRESS (If rural give location)

907 Old Oak Rd.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

OMAR

FRED

TARR

4. DATE (Month) (Day) (Year)

OF DEATH:

April 24,

19 55

5. SEX

male

6 COLOR OR RACE

white

7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

Dec. 15, 1892

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS

62

yr.

Months

Days

Hours

Min.

10A USUAL OCCUPATION (Give kind of work done during most of working life even if retired):

Vice President

10B KIND OF BUSINESS OR INDUSTRY:

Chemical Co.

11 BIRTHPLACE (State or foreign country):

Maine

12 CITIZEN OF WHAT COUNTRY?

13 FATHER'S NAME:

Fred P. Tarr

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

215 - 09 - 7262

14. MOTHER'S MAIDEN NAME:

Mary Hemeny

17. INFORMANT & ADDRESS:

Mrs. Lenora Tarr-907 Oak Oak Rd.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST

(B)

DUE TO

(C)

Carcinoma lung-Bilateral

INTERVAL BETWEEN ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)

INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 10 1955, to April 24 1955, that I last saw the deceased alive on April 24, 1955, and that death occurred at 2:30 AM, from the causes and on the date stated above.

SIGNATURE

Lawrence C. Tarr

M.D.

ADDRESS

M D 6805 York Rd Baltimore 12 Md

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

4/26/55

NAME OF CEMETERY OR CREMATORY

Lorraine Maus

LOCATION (City, town, or county) (State)

Woodlawn, Md.

DATE REC'D BY LOCAL REGISTRAR

4-26-55

REGISTRAR'S SIGNATURE

L. C. Tarr

24. FUNERAL DIRECTOR

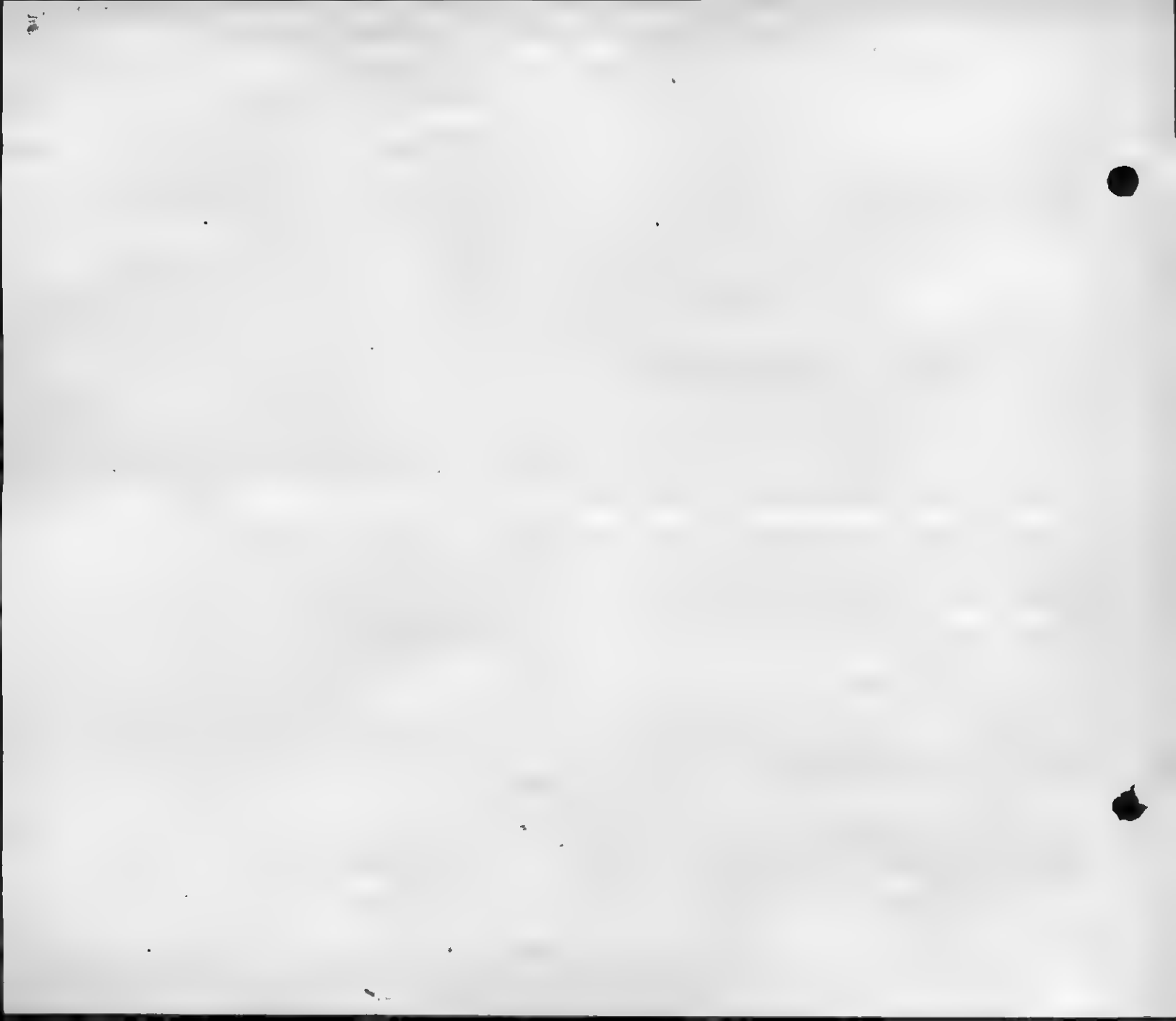
J. P. Tarr

ADDRESS

Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3489

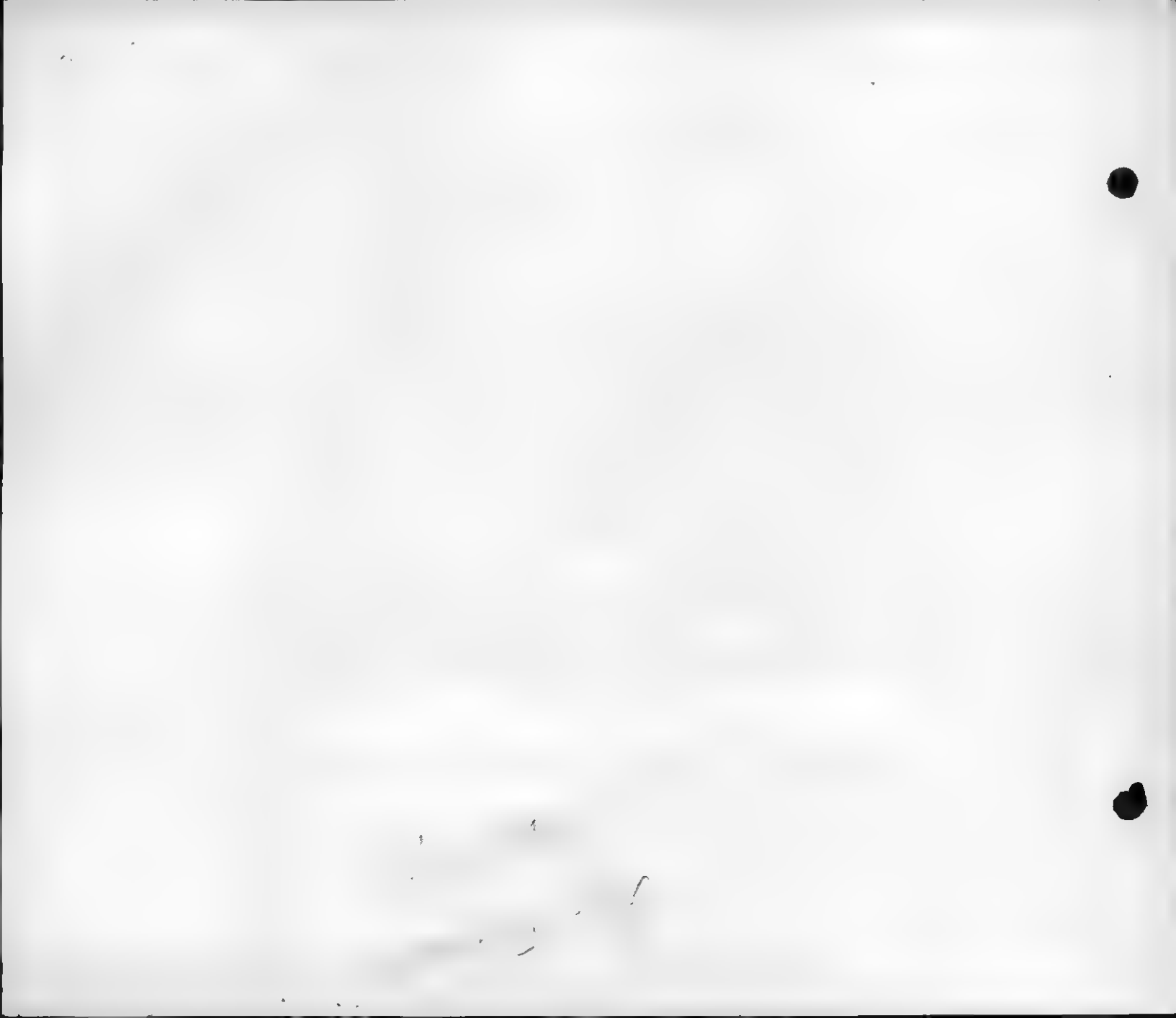
CERTIFICATE OF DEATH

Reg. Dist. No. 3/

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY
CITY (If outside cor. orate limits, write RURAL or a/l to nearest town)	LENGTH OF STAY (in this place)	CITY (If outside cor. orate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>ROCKHILL</u>	<u>64</u>	<u>BALTO. MD 3421-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>HUEBNER HOME</u>		<u>1422 HOMESTEAD ST. N</u>	
3. NAME OF DECEASED.		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Chie</u>		OF DEATH <u>4</u> / <u>10</u> / <u>1955</u>	
5. SEX: 1. M. 2. F. 3. OTHER	6. COLOR OR RACE	7. SINGLE MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH
<u>Female</u>	<u>White</u>	<u>WIDOW</u>	<u>JULY 15 1868</u>
9. AGE last birthday	10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>86</u>		<u>BALTO MD.</u>	
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	15. INFORMANT & ADDRESS:	
<u>CHRISTIAN STECK</u>	<u>LAWRENCE</u>	<u>6000 S. HUEBNER HOME</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service	17. SOCIAL SECURITY No.	18. MEDICAL CERTIFICATION	
		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		<u>420.0</u>	
		IMMEDIATE CAUSE	
		ANTECEDENT CAUSE (S)	
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE, LAST.	
		(A) <u>Anterior - Sclerotic Heart</u>	
		(B) <u>Ischemic</u>	
		(C)	
		11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
		<u>Generalized Anterior - Sclerotic</u>	
19A. DATE OF OPERATION	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY	
<u>None</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory) OF INJURY street, office bldg., etc.	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
<input type="checkbox"/>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 11</u> , 19 <u>51</u> , to <u>Sept. 19, 1955</u> , that I last saw the deceased alive on <u>Sept. 14 1955</u> , and that death occurred at <u>11:30</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Paul L. Chambers</u>		DATE SIGNED <u>4-19-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>URIAL</u>		<u>Paul L. Chambers</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-20-55</u>		ADDRESS <u>4108 Liberty Hts. Bldg. Baltimore 7, Md.</u>	
REGISTRAR'S SIGNATURE <u>A. W. Helms</u>			

MARGIN RESERVED FOR BINDING



3490

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL) <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>18 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1218 Angleser Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES P. THOMAS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 24, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>6-9-23</u>
9. AGE last birthday <u>31</u> yrs		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Thomas</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Barnaskis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>Yes</u> (If Yes, give war or dates of service) <u>WW-11</u>		16. SOCIAL SECURITY NO. <u>217-16-8673</u>	
17. INTERMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		9 YEARS	
IMMEDIATE CAUSE (A) <u>CHRONIC PYELONEPHRITIS</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 6, 1955, to April 24, 1955</u> , that I last saw the deceased <u>on April 24, 1955</u> and that death occurred at <u>2:10 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>William R. Vandergrift, M.D.</u>		DATE SIGNED <u>4-25-55</u>	
ADDRESS <u>M.D. VAH, Fort Howard, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 27, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>✓</u>	
24. FUNERAL DIRECTOR <u>William Cook Blight, Inc. Funeral Home</u>		ADDRESS <u>6009 Harford Road, Baltimore 11, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND

3491

03478
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 12 File 6181 5-9-55 et

1. PLACE OF DEATH: COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		CITY (If outside corporate limits, write RURAL and give nearest town) Parkville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7610 Old Harford Road		STREET ADDRESS (If rural, give location) 7610 Old Harford Road	
3. NAME OF DECEASED (Type or Print) Mr. Thomas Paton Thornton			
4. SEX male	5. COLOR OR RACE white	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	7. DATE OF BIRTH Jan. 5, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Long Shoreman		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME William Thornton		11. BIRTHPLACE (State or foreign country) Scotland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY No. 216-10-5919		14. MOTHER'S MAIDEN NAME Ninnie Brannan	
17. INFORMANT AND ADDRESS Mrs. Jean E. Thornton, 7610 Old Harford Rd.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
107. Immediate cause (a) ...		Antecedent cause(s) (b) ...		3 m.	
11. OTHER SIGNIFICANT CONDITIONS (c) ...		19a. DATE OF OPERATION 1/31/55		19b. MAJOR FINDINGS OF OPERATION Coronary artery disease	
19a. DATE OF OPERATION 1/31/55		19b. MAJOR FINDINGS OF OPERATION Coronary artery disease		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **1/24, 1955** to **4/30, 1955**, that I last saw the deceased alive on **4/30, 1955**, and that death occurred at **3:40 p.m.**, from the causes and on the date stated above.

SIGNATURE Henry J. Carroll		ADDRESS 13 C. Eager St		DATE SIGNED 2/27/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE May 3rd, 1955		NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
DATE REC'D BY LOCAL REG. 5-5-55		REGISTRAR'S SIGNATURE [Signature]		LOCATION (City, town, or county) Baltimore, Maryland	
24. FUNERAL DIRECTOR Leonard J. Ruck		ADDRESS 5305 Harford Road #14			

Dr. Harry Connelly .

13 E. Eager VE 7 7447 -2704

5221 Springlake Way HO 7 7150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

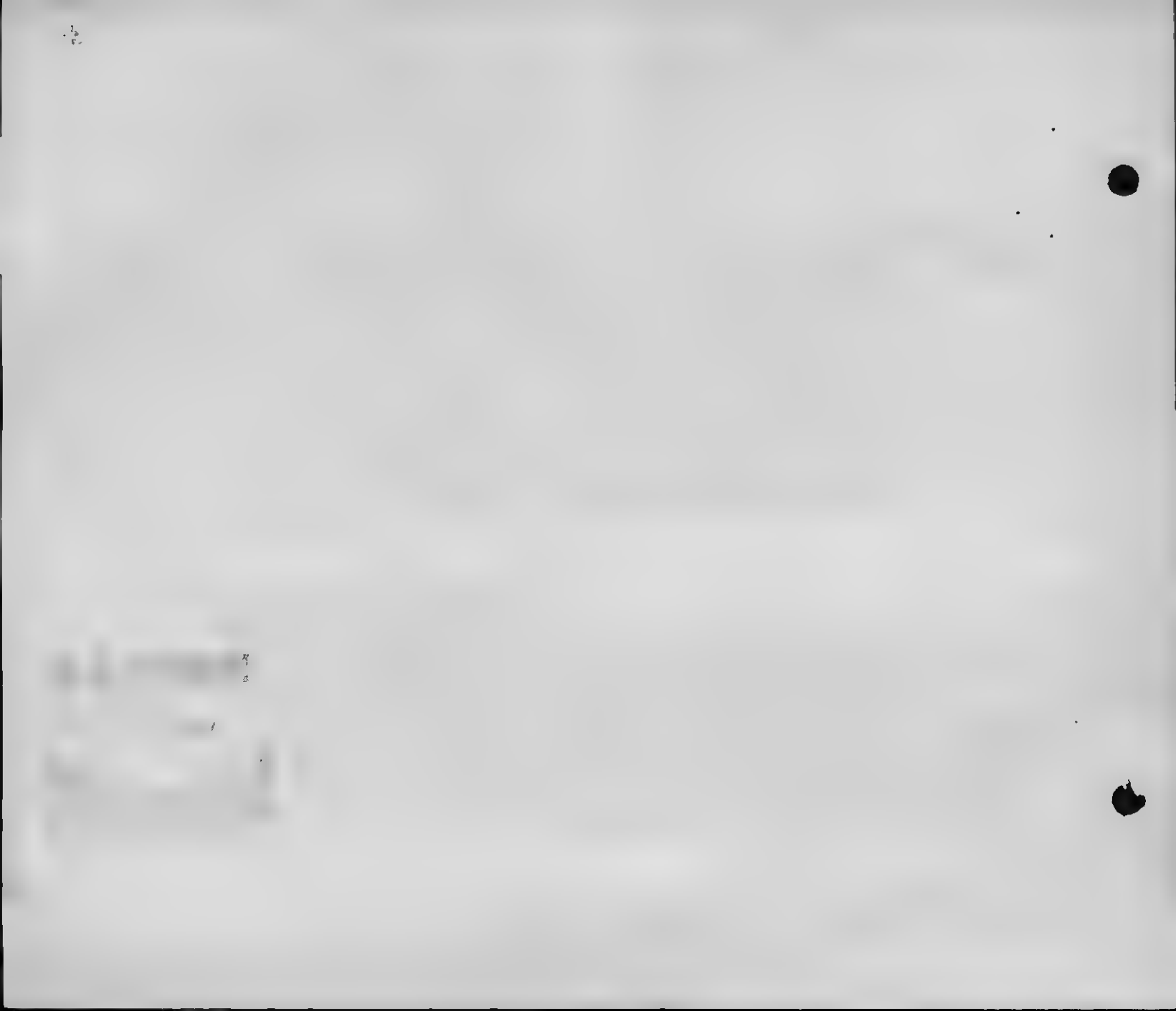
3361
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03479
Reg. Dist.

No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE CO.</u> MARYLAND				STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>DUNDALK</u>				CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>DUNDALK (22)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>701 SOUTH ST.</u>				STREET ADDRESS (If rural, give location) <u>271 DETROIT AVE.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>NICK</u> (Middle) <u>VITO</u> (Last) <u>TINELLI, JR.</u>				(Month) <u>4</u> (Day) <u>17</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>—</u>		8. DATE OF BIRTH: <u>Feb. 7, 1935</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		9. AGE last birthday: yrs. <u>20</u> Months <u>18</u> Days <u>18</u>		11. BIRTHPLACE (State or foreign country): <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME: <u>N. V. TINELLI, SR.</u>			
14. MOTHER'S MAIDEN NAME: <u>PATRICIA MALONE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY No.: <u>—</u>				17. INFORMANT & ADDRESS: <u>NICK V. TINELLI, SR. - #2 ABOVE</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
Immediate cause (a) <u>HEART FAILURE - STILL'S DISEASE</u>					
DUE TO <u>BILATERAL</u>					
Antecedent cause(s) (b) <u>—</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>—</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>					
19a. DATE OF OPERATION: <u>—</u>		19b. MAJOR FINDING OF OPERATION: <u>—</u>		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>—</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>—</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>R. B. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>4/17/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>4-20-55</u>		NAME OF CEMETERY OR CREMATORY: <u>OAK LAWN</u>	
LOCATION (City, town, or county) (State): <u>BALTO. Co. MD.</u>		24. FUNERAL DIRECTOR ADDRESS: <u>William M. Kelly, 2025 22nd St., Baltimore, MD.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

3492

03480

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u>	
TOWN <u>Carney</u>		TOWN <u>Carney</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9800 Magledt Ave</u>		STREET ADDRESS (If rural, give location) <u>9800 Magledt Ave Balto 3y</u>	
3. NAME OF DECEASED (First) <u>Nabel</u> (Middle) <u>F</u> (Last) <u>Trout</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>Jan 9-1922</u>
9. AGE last birthday <u>33 yrs.</u>		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto CO md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Clarence E Blakely</u>		14. MOTHER'S MAIDEN NAME <u>Anna E. Tinn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Mr John Trout 9800 Magledt Ave</u>	
17. INFORMANT AND ADDRESS			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Carcinomatosis</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Carcinoma of ovaries bilateral</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov, 1954, to April 16, 1955, that I last saw the deceased alive on April, 1955, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Morland Memorial Park</u>	LOCATION (City, town, or county) <u>Balto md</u>	(State)
DATE REC'D BY LOCAL REG. <u>4-18-55</u>	REGISTRAR'S SIGNATURE <u>R W Hedrick</u>	24. FUNERAL DIRECTOR <u>Lassalam Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11 E. Chase St 1-3 . 1

Pr. Diehl

5 7 787

3493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Baltimore	
X CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rodgers Forge		LENGTH OF STAY (in this place) 17 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rodgers Forge		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 206 Dunkirk Road				STREET ADDRESS (If rural, give location) 206 Dunkirk Road		/	
3. NAME OF DECEASED (Type or Print) Gertrude		(First) Lovett		(Last) Underwood		4. DATE OF DEATH (Month) (Day) (Year) April 3, 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW		8. DATE OF BIRTH May 10, 1873	9. AGE last birthday 81 yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Lovett				14. MOTHER'S MAIDEN NAME Tabitha Cross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No. -----		17. INFORMANT AND ADDRESS Miss Ethel S. Underwood 206 Dunkirk Road			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X
Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last(b) Hypertension, Cerebral Nephritis
(c) Cardiac Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

None

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 1, 1954 to Apr. 3, 1955, that I last saw the deceased alive on Apr. 3, 1955, and that death occurred at 10 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADD. SS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 6, 1955	NAME OF CEMETERY OR CREMATORY Druid Ridge	LOCATION (City, town, or county) Pikesville, Maryland	(State)
DATE REC'D BY LOCAL REG. 4-6-54	REGISTRAR'S SIGNATURE W. H. Hedden	24. FUNERAL DIRECTOR Burgee Funeral Home	ADDRESS 3631 Falls Road	

Norace F. Burgee

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03482
3494 CERTIFICATE OF DEATH Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Owings Mills</u>	<u>20</u> yrs	OR TOWN <u>Owings Mills</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Timber Grove Road</u>		STREET ADDRESS (If rural give location) <u>Timber Grove Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
(Type or Print) <u>Robert Clinton Utz</u>		OF DEATH: <u>April 29</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Apr 17 1878</u>
9. AGE last birthday <u>77</u> yrs.		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	11. BIRTHPLACE (State or foreign country): <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Robert O Utz</u>	
14. MOTHER'S MAIDEN NAME: <u>Hontas Vautis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>216-09-8874</u>		17. INFORMANT & ADDRESS <u>Mrs Lucy Lee Utz Owings Mills Md</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>few d</u>
ANTECEDENT CAUSE (S): (B) <u>hypertension</u>			<u>few yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerosis</u>			<u>few yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>			
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>✓</u>	
22. I hereby certify that I attended the deceased from <u>1-1-55</u> to <u>4-29-55</u> , that I last saw the deceased alive on <u>4-10-55</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James M. Saffell</u>		M. D. <u>Reisterstown Md 4-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 2 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		LOCATION (City, town, or county) <u>Reisterstown Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-30-55</u>		REGISTRAR'S SIGNATURE <u>James B. Shive</u>	
24. FUNERAL DIRECTOR <u>Wm Berryman & Sons</u>		ADDRESS <u>Reisterstown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

47 28-00-01

3495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03483

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cowings Mills</u>		STATE <u>Md.</u> COUNTY <u>Prince George</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Hyattsville, D.C.</u>	
OR TOWN <u>Cowings Mills</u>		LENGTH OF STAY (In this place) <u>7 mos</u>		OR TOWN <u>Hyattsville, D.C.</u>		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School</u>				STREET ADDRESS <u>8109 140th Ave.</u>			
3. NAME OF DECEASED: (First) <u>Robert</u> (Middle) <u>T. Jr.</u> (Last) <u>Vaughan</u>				4. DATE OF DEATH: (Month) <u>4</u> (Day) <u>15</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>Wt.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>S.</u>		8. DATE OF BIRTH: <u>8/24/54</u>	
9. AGE last birthday: <u>8</u> yrs.				IF UNDER 1 YEAR: Months <u>2</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>20</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY: <u>U. S. A.</u>		11. BIRTHPLACE (State or foreign country): <u>U. S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>				13. FATHER'S NAME: <u>Robert Thomas Vaughan</u>			
14. MOTHER'S MAIDEN NAME: <u>Jane Theresa E. Fox</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Ceiphyrization (food aspiration)</u>							
Antecedent cause(s) (b) <u>Chronic Brain Congenital (Amniocapital) Syndrome.</u>							
(c) <u>Amniotical Deficiency</u>							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>4/16/55</u> 19b. MAJOR FINDINGS OF OPERATION: <u>Respiratory tract obstruction</u>							
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT <input checked="" type="checkbox"/> (Specify) <u>SUICIDE</u>				PLACE (Home, farm, factory, street, office bldg., etc.) <u>Cowings Mills, Baltimore, Md.</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>4/14</u> , 19 <u>55</u> , to <u>4/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/15</u> , 19 <u>55</u> , and that death occurred at <u>9:30 p.m.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Wiles B. Johns</u>				DATE SIGNED <u>4-16-55</u>			
(DEGREE OR TITLE) ADDRESS							
23. BURIAL, CREMATION REMOVAL (Specify): <u>BURIAL</u>				DATE THEREOF <u>4/18/55</u>			
NAME OF CEMETERY OR CREMATORY <u>ST MARY'S</u>				LOCATION (City, town, or county) <u>FAIRFAX Station, VA</u>			
DATE REC'D BY LOCAL REG. <u>4/16/55</u>				24. FUNERAL DIRECTOR <u>Everly Funeral Home</u>			
REGISTRAR'S SIGNATURE <u>Marthy E. Newell</u>				ADDRESS <u>FAIRFAX, VA</u>			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

APR 22 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1803484
3496 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Ellicott City (Rural)</i>		LENGTH OF STAY (in this place) <i>17 yrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Ellicott City (Rural)</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Westchester Avenue</i>				STREET ADDRESS (If rural give location) <i>Westchester Avenue</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>ROYAL EDWARD WALL</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>April 10, 1955</i>			
5. SEX. <i>Male</i>	6. COLOR OR RACE. <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Feb. 22, 1902</i>	9. AGE last birthday <i>53 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Guard</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Industrial</i>		11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>John C. Wall</i>				14. MOTHER'S MAIDEN NAME: <i>Martha A. Litchfield</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-4135</i>		17. INFORMANT & ADDRESS: <i>Mrs. Royal E. Wall Westchester Ave. Ellicott City, Md.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>541.2</i>		(A) DUE TO <i>Coronary Thrombosis</i>				<i>1/2 hour</i>	
ANTECEDENT CAUSE (S)		(B) DUE TO <i>Cirrhosis of Liver</i>				<i>2 years.</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION <i>None</i>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 1, 1953</i> to <i>4/10, 1955</i> that I last saw the deceased alive on <i>Oct. 1, 1954</i> , and that death occurred at <i>9 P. M.</i> from the causes and on the date stated above.							
SIGNATURE <i>George E. Buntingford</i>				ADDRESS <i>M.D. Ellicott City</i>		DATE SIGNED <i>4/11/55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Apr. 14, 1955</i>		NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		LOCATION (City, town, or county) (State) <i>Ellicott City, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>4/13/55</i>		REGISTRAR'S SIGNATURE <i>V.E. Harris</i>		24. FUNERAL DIRECTOR <i>Easton Sons</i>		ADDRESS <i>Catonsville 28, Md.</i>	

BUREAU V. S.

APR 15 1965

105

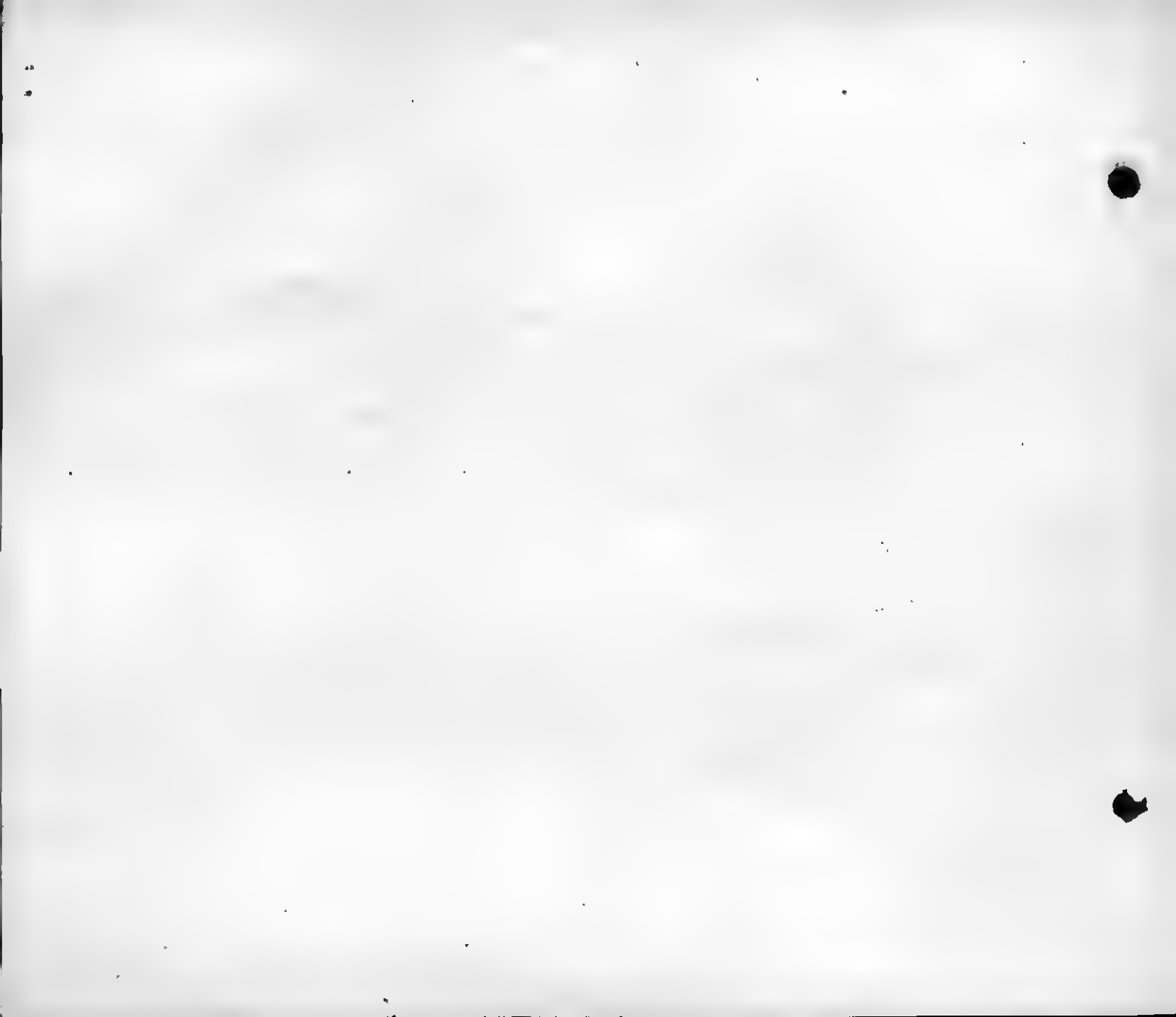
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 103485

3497 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Bello</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Halethorpe</u> STREET ADDRESS (If rural give location) <u>Second Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>Charles Henry</u> (First) (Middle) (Last) 5. SEX. <u>Male</u> 6. COLOR OR RACE. <u>White</u> 7. SINGLE, MARRIED, WIDOWED, DIVORCED. <u>Single</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 2, 1955</u> 8. DATE OF BIRTH (Month) (Day) (Year) <u>6/30/1897</u> 9. AGE last birthday <u>57</u> IF UNDER 1 YEAR (Month) (Day) (Hour) (Min.)	
10A. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) <u>Never worked</u> 10B. KIND OF BUSINESS OR INDUSTRY. <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Edward C. Walshe</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Briggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT & ADDRESS. <u>Mr. Robert J. Walshe - 615 Wilton Rd.</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>490X</u> IMMEDIATE CAUSE (A) <u>Lobar pneumonia</u> ANTECEDENT CAUSE (S) (B) <u>DUE TO</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Chronic arteriosclerotic heart disease years</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 21B. PLACE (If home, farm, factory or office bldg., etc.) OF INJURY 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2-24-</u> <u>1954</u> to <u>4-2-</u> <u>1955</u> that I last saw the deceased <u>alive on</u> <u>4-2-</u> <u>1955</u> and that death occurred at <u>7:10 AM</u> from the causes and on the date stated above. SIGNATURE <u>Frederick E. Phillips</u> ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>4-4-55</u> 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> DATE THEREOF <u>4/5/55</u> NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u> LOCATION (City, town, or county) <u>Woodlawn, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>5-5-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Phillips</u> FUNERAL DIRECTOR <u>Wm. J. Dickerson Sons - Baltimore</u> ADDRESS	



3498

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03486

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Towson		LENGTH OF STAY (In this place) 27 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Towson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60				STREET ADDRESS (If rural, give location) 10 Dixie Drive	
3. NAME OF DECEASED (Type or Print) J. Edwin Warwick		4. DATE OF DEATH April 26, 1955			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married	8. DATE OF BIRTH Mar. 16, 1894	9. AGE last birthday 61 yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President Baltimore Elec. Sup. Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William Warwick		14. MOTHER'S MAIDEN NAME Mary Hild		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. J. Edwin Warwick 10 Dixie Dr. Towson, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

141X Immediate cause (a) Carcinoma of the tongue	INTERVAL BETWEEN ONSET AND DEATH 1 yr
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____ (c) _____	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr. 26, 1955, to Apr. 26, 1955 that I last saw the deceased alive on _____, 19____, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/29/55	NAME OF CEMETERY OR CREMATORY Monte Marie	LOCATION (City, town, or county) Towson, Maryland	(State)
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DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE 4-27-55	24. FUNERAL DIRECTOR W. W. Meeks & Son 805 N. Calvert St.	ADDRESS
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

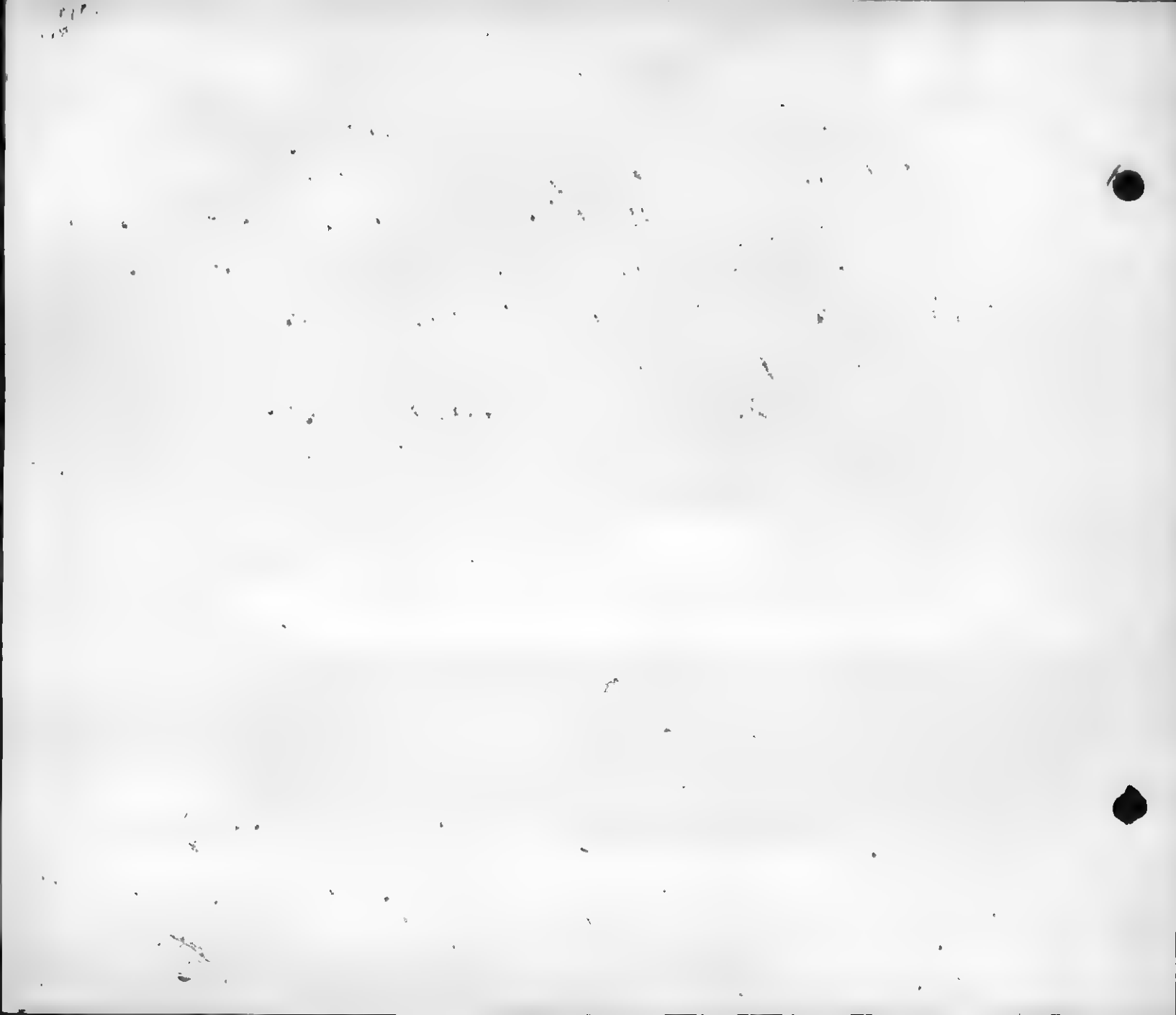
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3499
CERTIFICATE OF DEATH

03487

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>10 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	3V-1-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital,</u>		STREET ADDRESS (If rural give location) <u>1403 Mc Henry St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>SARAH REBECCA WEAVER</u>		DEATH: <u>4</u> <u>21</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/20/72</u>
9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	11. BIRTHPLACE (State or foreign country): <u>(U.S.A.) Indiana</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>	10B. KIND OF BUSINESS OR INDUSTRY: <u>O.H.</u>	11. BIRTHPLACE (State or foreign country): <u>(U.S.A.) Indiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>JACOB MURR</u>		14. MOTHER'S MAIDEN NAME: <u>MARY WEIGNER?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Margaret Evans 1404 Inverness Ave Balto. 30 Md</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X IMMEDIATE CAUSE		(A) <u>Senility</u>	
ANTECEDENT CAUSE (S):		(B) <u>Generalized Arteriosclerosis</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Diabetes Mellitus.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/11</u> , 19 <u>55</u> , to <u>4/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/21</u> , 19 <u>55</u> , and that death occurred at <u>10:50 PM</u> from the causes and on the date stated above.			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
<u>BURIAL</u>		<u>APR 25/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>LODGE PARK</u>		<u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR	
<u>25-53</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u> ADDRESS: <u>Harry H. Witke, 4101 EDMONDSON AVE</u>	



35 10

CERTIFICATE OF DEATH

Reg. Dist. No. 5/

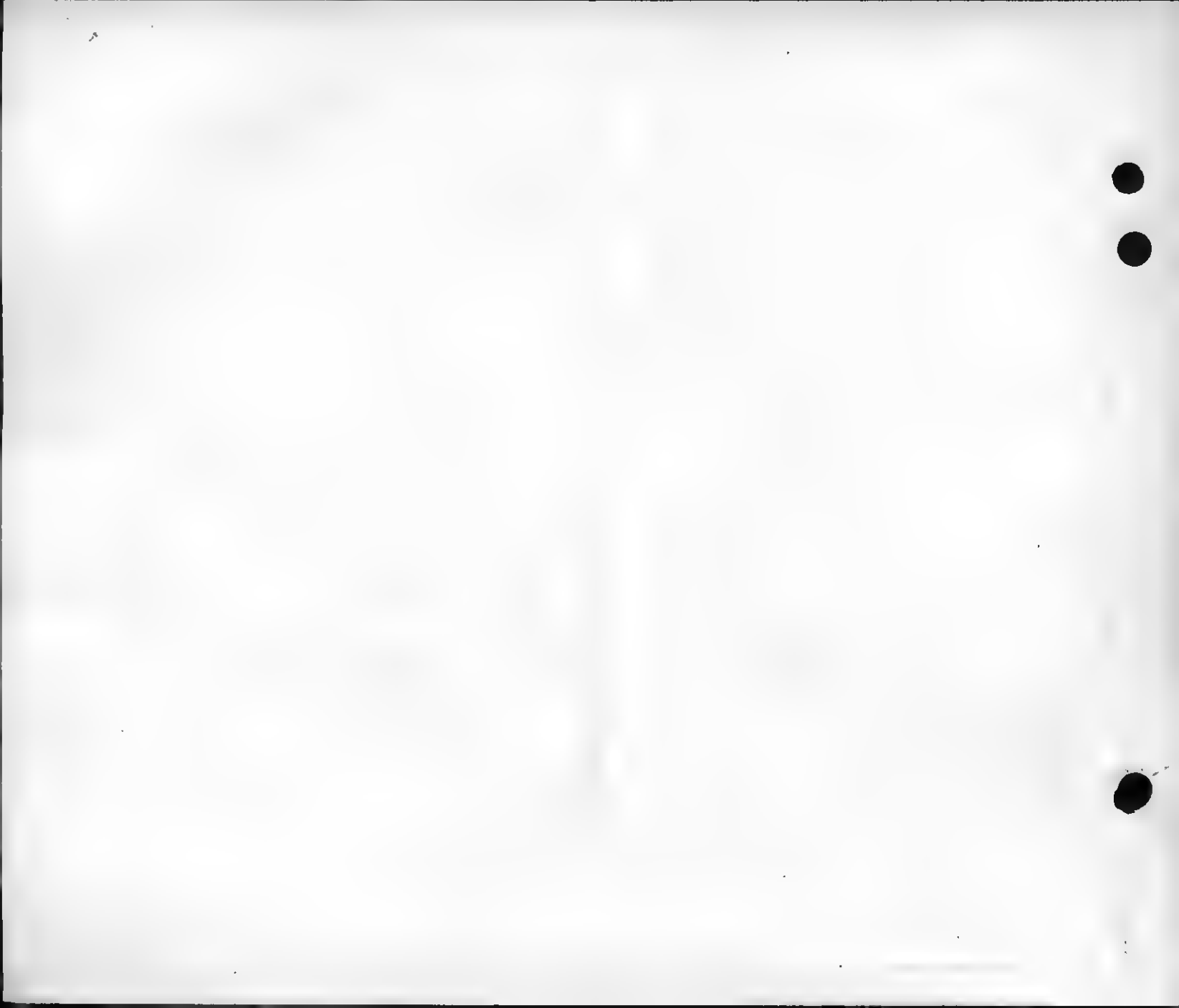
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore,		MARYLAND		STATE Maryland COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Woodlawn		1 yr.		OR TOWN Woodlawn X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7036 Windsor Mill Road				STREET ADDRESS (If rural, give location) 7036 Windsor Mill Road			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:			
(Type or Print) Walter Russell Welden				April 30, 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White	married	Feb. 12, 1889	66 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Fireman		10b. KIND OF BUSINESS OR INDUSTRY: Balto. City FireDept.		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME: William Thomas Welden				14. MOTHER'S MAIDEN NAME: Josephine V. Hall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mr. George Welden 2124 Mt. Holly St.			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
445X Immediate cause		(a) Malignant Hypertension & Hemip		2 years	
Antecedent cause(s)		(b) DUE TO		6 mos.	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c) DUE TO			
11. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. None					
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:	
20. AUTOPSY?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE		OF INJURY			
HOMICIDE					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF INJURY		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from July , 19 43 , to April 30 , 19 55 , that I last saw the deceased alive on April 29 , 19 55 , and that death occurred at 5 A. m., from the causes and on the date stated above.					
SIGNATURE Sam Ashman M.D.		(DEGREE OR TITLE)		ADDRESS 5907 Gwynn Oak Ave.	
23. BURIAL, CREMATION REMOVAL (Specify): Burial		DATE THEREOF May 3, 1955		LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.	
DATE REC'D BY LOCAL REG. 5-2-55		REGISTRAR'S SIGNATURE aw, Hedrick		24. FUNERAL DIRECTOR ADDRESS John O. Mitchell & Sons Inc., 1900 Eutaw Pl.	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No. *30*

CERTIFICATE OF DEATH

Reg. Dist. No. *30*

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>St. Charles</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Statenville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Statenville</u>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Catan Ridge Nursing Home</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>Sarah</u> (Middle) <u>Eliza</u> (Last) <u>Walsh</u>		4. DATE OF DEATH: (Month) <u>April</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb. 14 1868</u>
9. AGE last birthday: <u>87</u> yrs.	10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>housewife</u>		
11. BIRTHPLACE (State or foreign country): <u>St. Charles, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Walter Jensen</u>		14. MOTHER'S MAIDEN NAME: <u>Laura Virginia Jensen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: <u>-</u>	
17. INFORMANT & ADDRESS: <u>Mr. Frederick Jensen, 1707 Edmondson Ave, Statenville, Md.</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
(a) Immediate cause <u>Acute Chronic Congestive Heart Failure</u>			
(b) Antecedent causes (s) <u>Arteriosclerosis Generalized Degenerative Myocarditis</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>April 16 1955</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <u>Yes</u> <input checked="" type="checkbox"/> <u>No</u> <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept. 1, 1953</u> to <u>April 16, 1955</u> , that I last saw the deceased alive on <u>April 14, 1955</u> , and that death occurred at <u>2:51 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. H. G. D. D.</u> (Degree or title)		ADDRESS <u>1707 Edmondson Ave, Statenville, Md.</u> DATE SIGNED <u>April 18 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>April 19 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Statenville Cemetery</u>	LOCATION (City, town, or county) (State) <u>Statenville, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>April 19 1955</u>	REGISTRAR'S SIGNATURE <u>Victor E. Barry</u>	24. FUNERAL DIRECTOR <u>Dr. H. G. D. D.</u> ADDRESS <u>Statenville, Md.</u>	

RECEIVED
APR 11 1983

03450

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

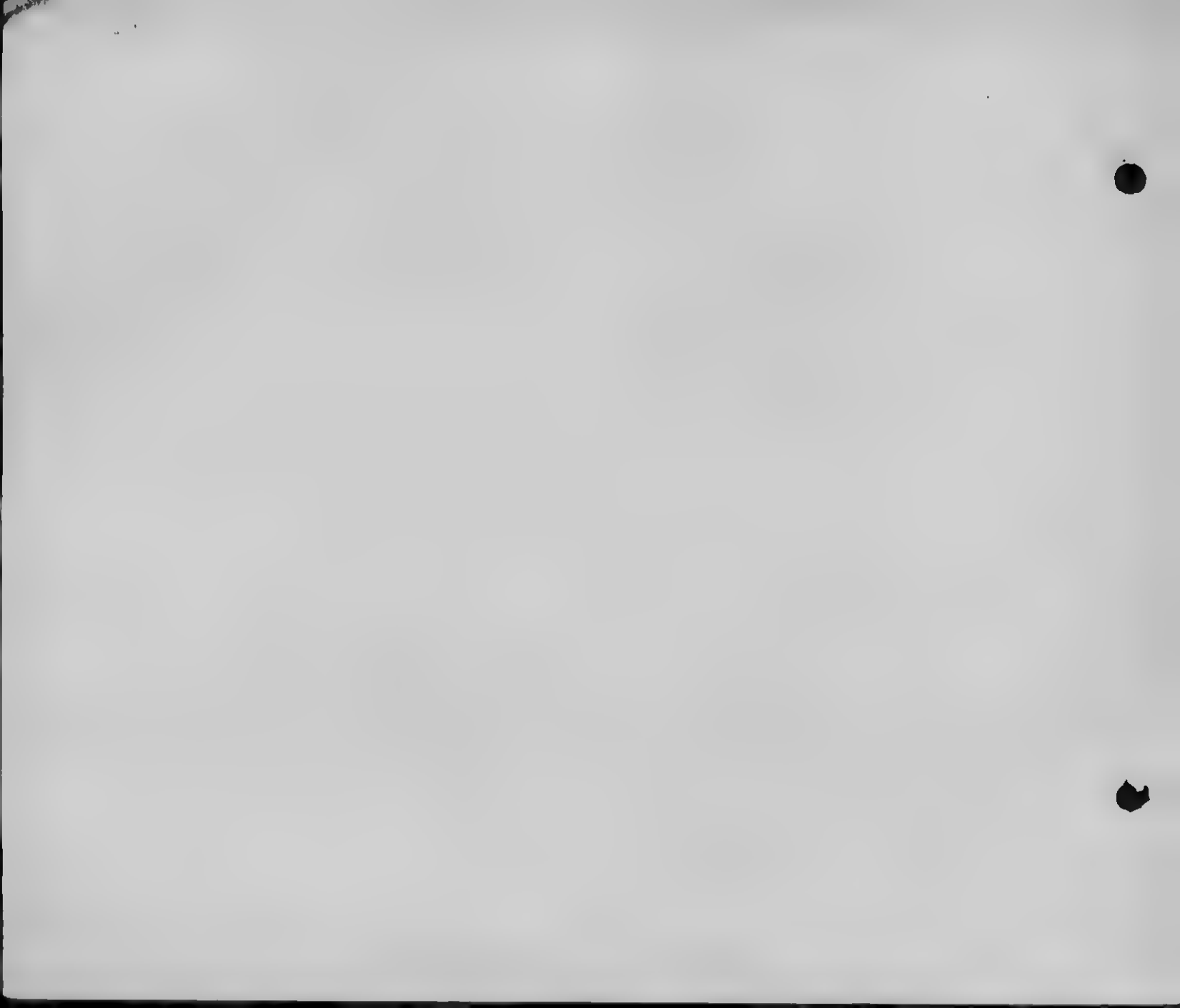
Reg. Dist. No. 38

352

1. PLACE OF DEATH- COUNTY BALTO		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MD. COUNTY BALTO	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) (RURAL) COCKEYSVILLE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS STATE TEACHERS COLLEGE		STREET ADDRESS (If rural, give location) 1 MI. NR. OF COCKEYSVILLE	
3. NAME OF DECEASED (Type or Print)	(First) JOE (Middle) YOUNG (Last) WEST	4. DATE OF DEATH (Month) (Day) (Year) Apr 1 29 1955	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) SINGLE	8. DATE OF BIRTH JAN. 3, 1904
9. AGE last birthday 51 yrs.		10. BIRTHPLACE (State or foreign country) MISSISSIPPI	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JOSEPH J. WEST		14. MOTHER'S MAIDEN NAME LILY BROWNING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-34-1138	
17. INFORMANT AND ADDRESS PAUL M. WEST SPARKS, MD		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Cerebral Thrombosis		Sudden	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
2. OTHER SIGNIFICANT CONDITIONS (c) Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes, accident, suicide, homicide, undetermined.			
SIGNATURE Charles F. O'Donnell MD		ADDRESS 7501 York Rd Towson 4 MD	
DATE SIGNED 4/29/55			
AL CREMATION MOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY LORRAINE PARK		LOCATION (City, town, or county) BALTO	
STATE MD.			
DATE REC'D BY LOCAL REG. 5-2-55		REGISTRAR'S SIGNATURE AW Hedrick	
23. FUNERAL DIRECTOR H. W. JENKINS & SONS CO		ADDRESS 4405 YORK ROAD BALTO. 13 MD	

MARGIN RESERVED FOR BINDING

CASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

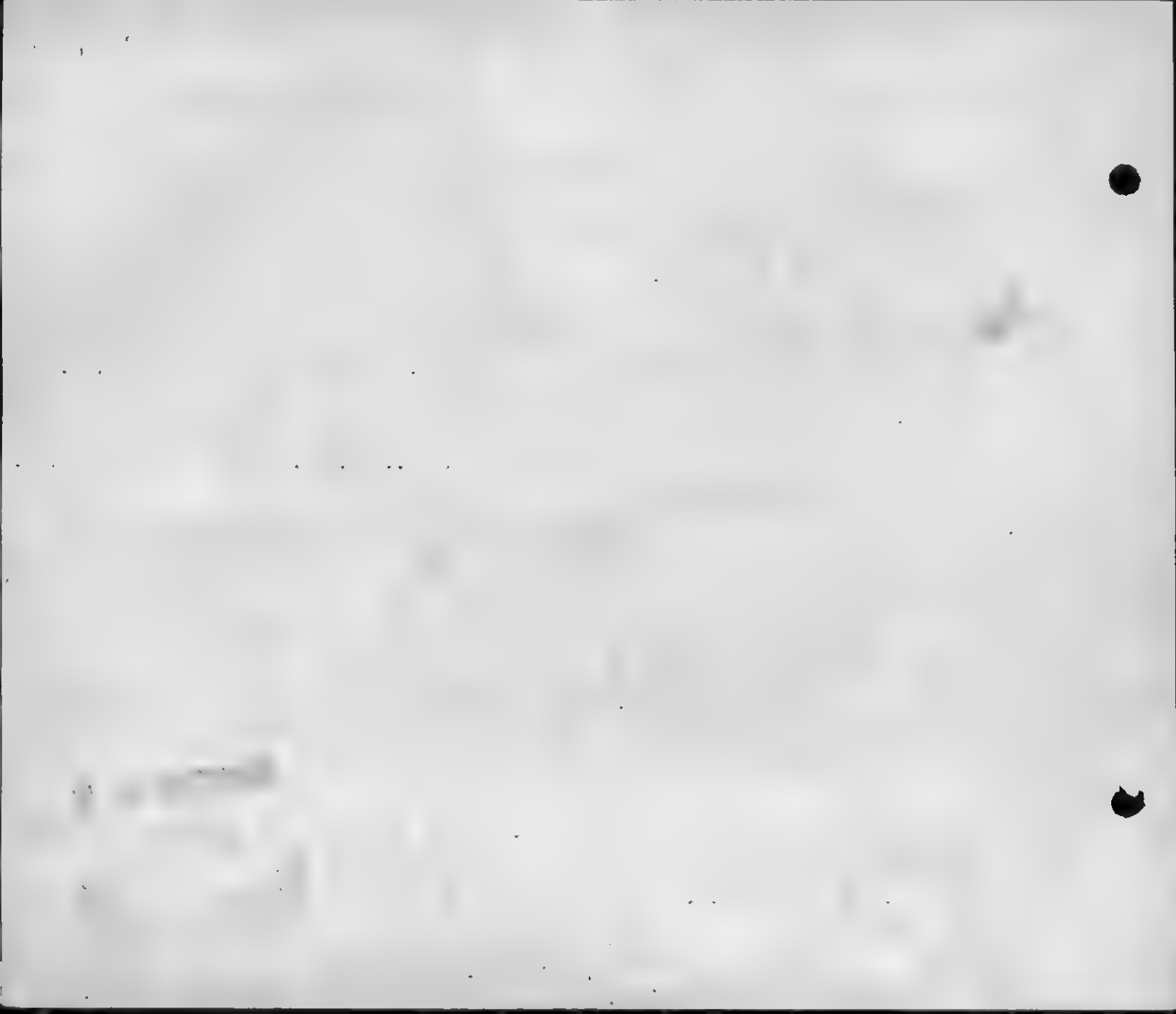
Reg. Dist. No.

Item 22, Fil. 3180 4-22-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Pennsylvania</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>147 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>York</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>133 West King Street</u>	
3. NAME OF DECEASED: (First) <u>STEWART</u> (Middle) <u>C.</u> (Last) <u>WHITE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>April 12 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12/29/11</u>
9. AGE last birthday <u>43</u> yrs.		10. AGE UNDER 1 YEAR: Months <u>12</u> Days <u>12</u> Hours <u>19</u> Min.	11. BIRTHPLACE (State or foreign country): <u>Keymar, Maryland</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bus Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Grey Hound</u>	12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>
13. FATHER'S NAME: <u>James C. White</u>		14. MOTHER'S MAIDEN NAME: <u>Clara Zent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>204 05 1202</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>MYELOID METAPLASIA OF SPLEEN</u>			UNKNOWN
ANTECEDENT CAUSE (B) <u>DUE TO UNKNOWN</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2-18-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Splenectomy Dg. Myeloid Metaplasia of spleen</u>	
19C. DATE OF OPERATION: <u>3031-55</u>		19D. MAJOR FINDINGS OF OPERATION: <u>Exploratory Laparotomy - No surgical disease found</u>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 17, 1954, to April 12, 1955, and that death occurred at 5:10 PM, from the causes and on the date stated above.			
SIGNATURE <u>William B. VandeGrift, M.D.</u>		ADDRESS <u>M. D. VAH, Fort Howard, Maryland 4-13-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>APR. 13, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Mt. Rose Cemetery</u>		LOCATION (City, town, or county) (State) <u>York, Pennsylvania</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1955</u>		24. FUNERAL DIRECTOR <u>Wm. Cook-Bright Funeral Home, Inc.</u>	
SHIPPED TO: <u>E. Market Street, York, Pennsylvania</u>		ADDRESS <u>4009 Harford Road, Baltimore 14, Md.</u>	

MARGIN RESERVE FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3594

CERTIFICATE OF DEATH

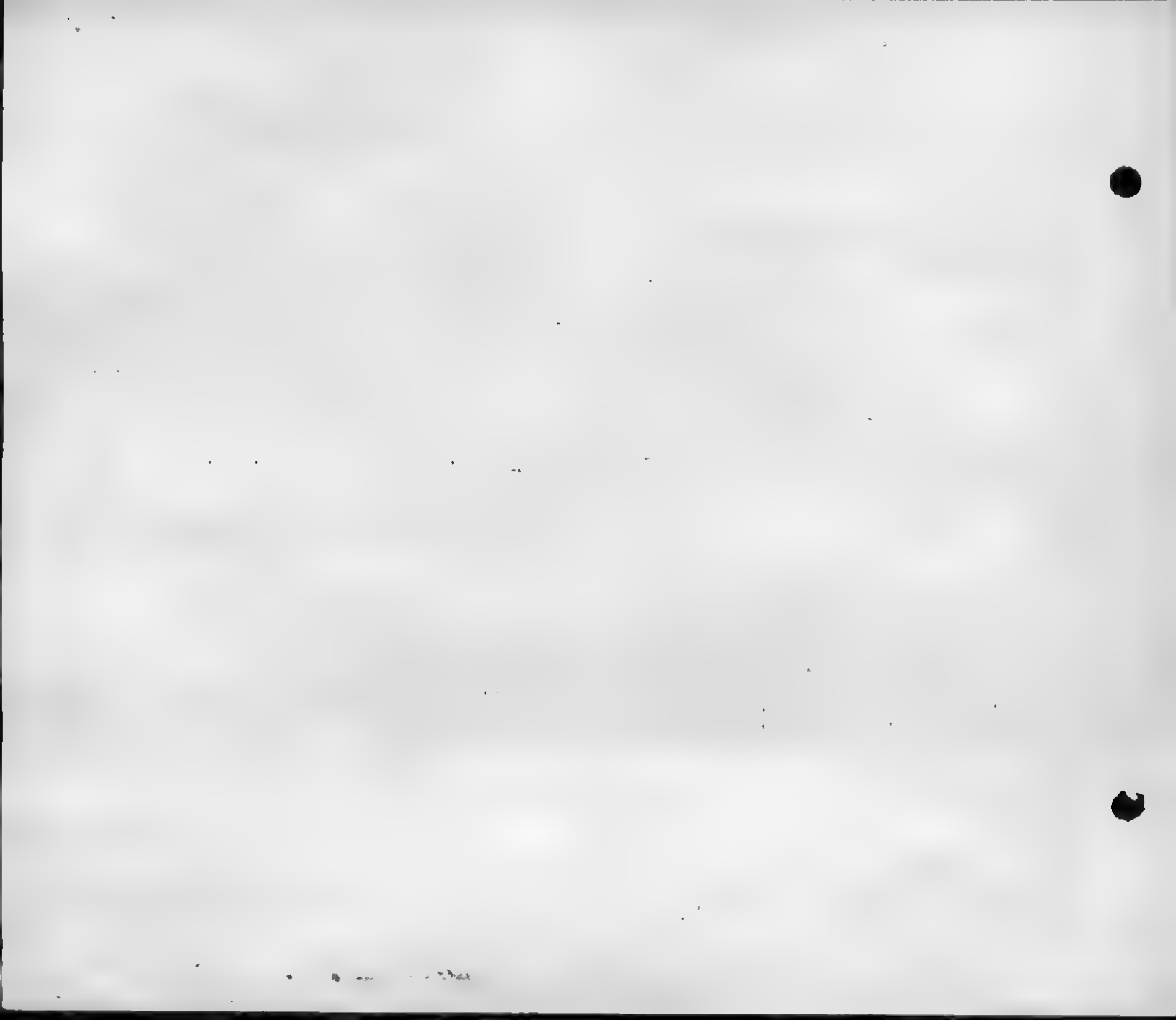
Reg. Dist. No. 47

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY _____
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>268 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>3001</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>	STREET ADDRESS (If rural give location) <u>4439 Pen Lucy Road</u>		
3 NAME OF DECEASED (First) (Middle) (Last) <u>JAMES R. WHITEHILL</u>	4. DATE (Month) (Day) (Year) OF DEATH <u>April 24, 1955</u>		
5 SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7 SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>2-6-93</u>
9. AGE last birthday <u>62</u> yrs	10. MONTHS <u>0</u>	11. DAYS <u>0</u>	12. HOURS <u>0</u>
10A USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Meat Cutter</u>	10B KIND OF BUSINESS OR INDUSTRY: <u>Liberty Food Markets</u>	11 BIRTHPLACE (State or foreign country): <u>Unionville, Maryland</u>	12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>John W. Whitehill</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Barnes</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> If Yes, give war or dates of service: <u>WW-1</u>		16 SOCIAL SECURITY NO: <u>220-05-5372</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>602x</u>			
ANTECEDENT CAUSE (S): <u>STRICTURE AND FISTULA OF LEFT URETER WITH PYONEPHROSIS</u>		<u>9 Months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>RIGHT NEPHRECTOMY</u>		<u>13 Years</u>	
19A DATE OF OPERATION <u>1-9-54, 2-12-54, 3-4-55, 4-4-55</u>	19B MAJOR FINDINGS OF OPERATION <u>1. Ureterolithotomy; left; 2. Ureteroplasty, left; 3. Ureteroneocystostomy; 4. Closure of Wound Dehiscence</u>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A ACCIDENT WAS UNDERLYING NG <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B PLACE (Home, farm, factory, street, office bldg., etc)	21C WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 30, 1954, to April 24, 1955</u> , that I last saw the deceased on <u>April 24, 1955</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>William B. Vandegrift, M.D.</u>		ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>4-25-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>4/27/55</u>	NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>4-27-55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. ADDRESS <u>[Signature]</u>	ADDRESS <u>[Signature]</u>

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



3505

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. NAME OF DECEASED (Type or Print) JAMES M. WILLIAMS			2. DATE OF DEATH April 22, 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland 2507 Wentworth Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		
B. FULL NAME OF HOSPITAL OR INSTITUTION Baltimore County - Parkville - 14			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore		
C. Length of stay in Baltimore 68 Years			D. STREET ADDRESS (If rural, give location) 2507 Wentworth Road		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH March 17, 1872		9. AGE (In years last birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10B. KIND OF BUSINESS OR INDUSTRY American Stores Co.		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME (unknown) Williams		
14. MOTHER'S MAIDEN NAME George White			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		
16. SOCIAL SECURITY NO. 217 -05-1624			17. INFORMANT ADDRESS Mrs. Rebecca E. Williams 2507 Wentworth Rd.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Cancer of Stomach			INTERVAL BETWEEN ONSET AND DEATH 1 year		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Scirrhoty					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21. TIME (Month) (Day) (Year) (Hour) OF INJURY None			22. I certify that (I) (this hospital) attended the deceased from April 22, 1955 to April 22, 1955 , that (I) (we) last saw the deceased alive on 4-19 , 19 55 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above.		
23A. SIGNATURE Dr. J. J. Gandy			23B. DATE SIGNED 4-23-55		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE April 25, 1955		
24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		
25. FUNERAL DIRECTOR Wm. C. Bacon			ADDRESS 6009 Harford Road		

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DEATH.

MIL CERTIFICATION

RECEIVED

APR 26 1955

BUREAU V. S.

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Woodlawn</u> TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Woodlawn</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7007 Windsor Mill Road</u>		STREET ADDRESS (If rural, give location) <u>7007 Windsor Mill Road.</u>	
3. NAME OF DECEASED (Type or Print) <u>HORACE VERNON WINDSOR</u>		4. DATE OF DEATH <u>April, 1st</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 22nd</u> 1877
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Pattern Maker</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year: Months _____ Days _____ If under 24 hrs: Hours _____ Min. _____
10a. BIRTHPLACE (State or foreign country) <u>Howard Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Brewer Windsor</u>		14. MOTHER'S MAIDEN NAME <u>Harriet E. Dudrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, if yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY No. <u>212-10-4946</u>	
17. INFORMANT AND ADDRESS <u>Mrs. H. Vernon Windsor 7007 Windsor Mill Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Thrombosis	24 hours
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the <u>underlying cause last</u>	(b) Arteriosclerotic Cardiovascular Disease	5 years
	(c) Senility	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
no operation						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY							
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED		HOW DID INJURY OCCUR?	
OF				While at	Not While		
INJURY			m.	Work <input type="checkbox"/>	At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from Sept 25, 1934, to April 1, 1935, that I last saw the deceased alive on April 1, 1935, and that death occurred at 10.45 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<i>[Signature]</i>		<i>[Address]</i>	<i>[Date]</i>

SIGNATURE

SIGNATURE Joshua H. Armacost MD. (Degree or title)

ADDRESS

ADDRESS
6419 Windsor Mill Rd
Baltimore 7 Md

DATE SIGNED _____

23 BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
BURIAL	April, 4 th 1955	MT. OLIVE CEMETERY	RANDALLSTOWN, BALTO.CO.	MD.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS	
4-4-55	<i>Howe Hedrick</i>	<i>Willis Lamoreaux</i>	4510 Liberty Heights Ave	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

